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No. 92-580

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1992

LINDA BROWN MARSHALL and DONALD MARSHALL,
Petitioners,

v.

BANKERS LIFE AND CASUALTY COMPANY, an Illinois Corporation, FRANK B. HALL AND COMPANY OF CALIFORNIA, a California Corporation, and MIA ADMINISTRATORS, a California Corporation,
Respondents.

Petition for Writ of Certiorari to the Supreme Court of California

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PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Does an employer establish and maintain an "employee benefit plan" pursuant to ERISA (29 U.S.C. §§ 1001 *et seq.*), so as to preempt an employee's state law claim for insurance bad faith, when the employer merely purchases a health benefits insurance policy and the employer's activity relating to that policy is limited to paying premiums for employee coverage and withholding the cost of dependent coverage from employees' pay, forwarding premiums to the carrier and distributing claims forms and information to employees, and when the employer never intended to establish a "plan" under ERISA and was under no obligation to provide the benefits and retained the right (which it ultimately exercised) to cancel the insurance at any time?

PARTIES TO THE PROCEEDING

The parties to the proceeding in the Supreme Court of California were Linda Brown Marshall and Donald Marshall, Petitioners in this Court, and Bankers Life and Casualty Company and Frank B. Hall and Company of California, who are Respondents in this Court.

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PETITION FOR WRIT OF CERTIORARI

Petitioners Linda Brown Marshall and Donald Marshall respectfully pray that a writ of certiorari issue to review the judgment and opinion of the Supreme Court of California, entered in this matter on July 9, 1992.

OPINIONS BELOW

The opinion of the Supreme Court of California is reported at 2 Cal.4th 1045, and is reprinted at Appendix A, hereto.

The Supreme Court of California reversed a decision of the California Court of Appeal for the Second Appellate District, Division Three, which decision had been filed on June 10, 1991, and modified on July 10, 1991.

That decision as modified, is reprinted at Appendix B, hereto.

The Court of Appeal had reversed an April 5, 1990 judgment of the Superior Court for the County of Los Angeles, dismissing the action, which judgment is reprinted at Appendix C, hereto.

JURISDICTION

The judgment of the Supreme Court of California was entered on July 9, 1992. This Court has jurisdiction pursuant to 28 U.S.C. § 1257(a).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

29 U.S.C. § 1002(1), defining "employee welfare benefit plan"; 29 U.S.C. § 1132(a), describing private civil enforcement actions under ERISA; 29 U.S.C. § 1144(a) and (b) describing the preemption of state laws relating to employee benefits plans, and 29 C.F.R. § 2510.3-1(j), the Secretary of Labor's regulation suggesting criteria under which an insurance policy should not be considered to be an employee benefit plan, are all set forth at Appendix D, hereto.

STATEMENT OF THE CASE

Linda Marshall's claim for payment of hospitalization expenses was denied by her health insurance carrier, Bankers Life. Bankers claimed that she was suffering from a preexisting condition, sickle cell anemia, even though, as alleged in the complaint, the carrier knew at that time that she was being treated for the aftereffects of an aneurysm and brain surgery. *Fourth Amended Complaint* at ¶¶ 11, 13. As a result, Linda Marshall was prematurely discharged from the hospital. *Id.* at ¶ 11. Bankers Life resisted the Marshalls' repeated requests for payment of the hospitalization expenses over a period of some twenty months, until the Marshalls retained a

lawyer, at which time, Bankers Life paid the disputed claim. *Id.* at ¶¶ 13, 16. This insurance bad faith action, under the laws of California, followed.

Linda Marshall was an insured under a medical benefits insurance policy to which her husband, Donald Marshall, subscribed at his place of employment, Miller Imports, an automobile dealer. As an affirmative defense, Bankers Life asserted that all causes of action were preempted by the federal Employees' Benefits Income Security Act (29 U.S.C. §§ 1001 *et seq.*) ("ERISA"). Both sides moved, unsuccessfully, for summary judgment on the issue of ERISA preemption, and ultimately, that issue was separated out and tried in the superior court on stipulated facts. (The Stipulation is reprinted at Appendix E, hereto.)

The Bankers Life policy was effective from March 1, 1983 to October 1, 1983. Through a separate contract with Bankers, Frank B. Hall Company and MIA Administrators administered the health insurance program, for which they received a monthly fee from Bankers for each covered employee. Hall/MIA billed the employer, Miller Imports, monthly. Miller paid the employees' premiums, including Donald Marshall's, and deducted premiums for dependent coverage from the paychecks of employees who had elected dependent coverage. Thus, Donald paid for Linda's health insurance coverage. Miller did not set aside a separate account to pay these premiums; rather, it paid them from its operating account.

Miller provided Bankers and Hall/MIA with current lists of employees and passed on enrollment cards which were filled out by employees, but Bankers and Hall/MIA exclusively determined whether employees and dependents were eligible for benefits. Miller was provided with claims forms which it passed on to employees, but all completed forms were submitted directly to Hall/MIA by the employee or the health care provider; Miller did not review

claims forms and had no responsibility for evaluating claims. Miller passed along to employees a booklet and a letter provided by Hall/MIA explaining the policy and how to file claims; and while Miller would attempt to answer employee questions, Hall/MIA had instructed Miller to have employees direct all questions to it. All decisions on claims payment were made by Bankers and Hall/MIA which paid benefits directly to employees or providers.

Miller never handled funds used for the payments of benefits, and had no opportunity to misappropriate or improvidently invest those funds, nor did it have responsibility for monitoring those funds. Miller never intended to create an ERISA Plan. Miller reserved the right to cancel the insurance at any time, and it did cancel the Bankers policy, which was in effect for only seven months.

The superior court concluded that the employer's involvement in the program was not extensive, and that the employer did not specifically intend to establish a program which would be covered by ERISA. Relying, in part, upon the Secretary of Labor's so-called "safe harbor" regulation (29 C.F.R. § 2510.3-1(j), the superior court found that the insurance policy provided benefits of the type typically covered by ERISA and was an employee benefit plan within the meaning of ERISA, and accordingly, that all of the Plaintiffs' causes of action were preempted. *See*, 29 U.S.C. § 1144(a).

The California Court of Appeal reversed. Relying on the distinction which this Court drew in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), the court of appeal's underlying premise was that ERISA preempts only state laws relating to employee benefit plans, not state laws relating merely to employee benefits. The Act does not define "plan" and the court of appeal examined the employer's involvement in the administrative aspects of the insurance policy to determine whether that involvement was of the nature which implicated the concerns

which gave rise both to ERISA and to ERISA's preemption provisions.

The court of appeal concluded that Miller Import's involvement in the Bankers Life policy did not implicate those concerns. Noting that Miller was not obligated to provide the insurance benefit for its employees, and that it could, and ultimately did, cancel the policy, the court concluded that Miller had no "commitment systematically to pay [these] benefits. . . ." and that what was involved was " 'a bare purchase of insurance' [citation deleted] and a temporary one at that." *Court of Appeal Decision*, App. B at 40a. Finding that Bankers and Hall/MIA (not Miller) determined the eligibility of claimants for benefits, calculated benefits, and paid them, and that Hall/MIA (and not Miller) was responsible for keeping records and monitoring the availability of funds to pay claims, the court concluded that Miller's role was limited to paying the premiums and performing ministerial tasks, and accordingly, that an employee benefit plan had not been established and that Plaintiffs' state law-based causes of action were not preempted.

The court of appeal noted that neither Hall/MIA nor Miller had complied with any of the ERISA reporting requirements, nor with the regulations requiring that employees be provided with a statement of their rights under ERISA. The court of appeal noted the context of the issue before it; that the employer, without intent to create an ERISA plan, had purchased an insurance policy, and the insurer sought to elevate that fact to the level which would permit it to avoid liability for its bad faith in handling claims under the policy.

> In short, the insurer seeks the protection of a federal regulatory scheme without any evidence that any of the purposes or concerns, which Congress had when it enacted that regulatory scheme, were in any way implicated. Although Miller's employees had none of the protections or benefits or a bona fide ERISA plan, the

> insurer now seeks to use the illusion of such a plan to deprive them of the benefits of state laws regulating insurer misconduct. *Id.*, App. B at 43a.

The Supreme Court of California, with one justice dissenting, reversed, holding that "despite the employer's minimal involvement in plan administration and complete noninvolvement in claims processing" an employee benefit plan was established, and accordingly, that the state law actions were preempted. *California Supreme Court Decision*, App. A at 1a-2a.

The court viewed *Fort Halifax* v. *Coyne* as distinguishable because in that case the payments were to be made directly by the employer. Determining that in cases where the benefits are secured through an insurance policy, the extent of employer involvement in plan administration is not a relevant consideration in determining the existence of an employee benefit plan (*California Supreme Court Decision*, App. A at 8a), the court instead focused on the test articulated by the 11th Circuit in *Donovan* v. *Dillingham* (688 F.2d 1367, 1373 (11th Cir. 1982) (en banc)): a plan exists if the court may determine " 'whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits.' " *California Supreme Court Decision*, App. A at 9a. The court concluded that these criteria were easily met in this case: the intended benefits were the payment of health benefits; the beneficiaries were Miller's employees and their dependents; the source of financing was the premiums; and the procedure for securing benefits was to submit a claim to Hall/MIA on a form secured from Miller. *Id.*, App. A at 9a-10a.[1]

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[1] In his dissenting opinion, Justice Mosk pointed out that any employer purchase of insurance would perforce meet these criteria (*California Supreme Court Decision*, App. A. at 22a (Mosk Dissenting)) thus blurring the distinction between an employee benefit and an employee benefit plan, where the benefit was secured through purchase of insurance.

The court determined that the Plan was an ERISA plan because it provided benefits of the type specified in the ERISA statute, and because it was established and maintained by the employer. With respect to this latter, the court noted that while the four criteria in the Secretary of Labor's safe habor regulations were not met in this case, that regulation was not intended to be conclusive on the issue. The court reasoned that while the " 'bare purchase' of insurance . . . with no employer endorsement or involvement other than deducting premiums from employees' paychecks and forwarding them to the insurer—does not conclusively establish the existence of an ERISA plan" the fact that Miller actually paid employees' premiums is "evidence" that an ERISA plan was established and maintained and "the purchase of a policy covering a class of employees offers substantial evidence that the employer has established a plan." *Id.*, App. A at 11a.

REASONS FOR GRANTING THE WRIT

In its decision, Division Three of the Second Appellate District styled the Miller Imports/Bankers Life arrangement as a "garden variety employee health insurance benefit". *Court of Appeal Decision*, App. B at 37a. In its *amicus* brief to the Supreme Court of California, the Association of California Life Insurance Companies asserted that "[o]f the estimated 4.5 million employer-sponsored health care plans the overwhelming majority are established simply by the employer's purchase of insurance." *Amicus Brief in Supreme Court of California* at p. 7. Indeed, this is the most common arrangement of insuring for health care costs in the United States; 150,073,000 persons in the United States are covered by health insurance related to the current or past employment of themselves or a relative. *Poverty in the United*

States: 1991, Series P60, Number 181, U.S. Bureau of the Census, p. 149.[2]

Notwithstanding the significance of the question, there remains a split in authority among both federal and state courts as to whether an employer's purchase of a health insurance policy with little more constitutes the establishment of an ERISA plan. The Sixth, Seventh, Ninth and Eleventh Circuits would say that such a purchase of insurance established a "plan",[3] while authority in the Fifth Circuit [4] would say that no "plan" was established. The instant case places the Supreme Court of California directly in conflict with the Nevada Supreme Court decision in *Turnbow* v. *Pacific Mutual Life Ins. Co.*, 765 P.2d 1160 (Nev. 1988), *cert. denied*, 490 U.S. 1102 (1989).

Thus, a clear determination of whether such routine insurance policies are ERISA Plans will define for tens of millions of insureds in these types of insurance arrangements their remedies for egregious bad faith. The insured's remedy under ERISA is most generally limited to compelling the carrier to pay the benefits called for in the insurance contract. If the insureds question these denials of coverage, if they can secure legal assistance, if

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[2] The health insurance industry reports, similarly, that the number of individuals whose health insurance is provided through an employment relationship is 153,800,000 in 1989. *Source Book of Health Insurance Data: 1991*, Health Insurance Association of America, Table 1.1.

[3] *International Resources* v. *New York Life Ins. Co.*, 950 F.2d 294 (6th Cir. 1991); *Fugarino* v. *Hartford Life and Acc. Ins. Co.*, 969 F.2d 178 (6th Cir. 1992); *Brundage-Peterson* v. *Compcare Health Services Insurance Corp.*, 877 F.2d 509 (7th Cir. 1989); *Kanne* v. *Connecticut General Life Insurance Co.*, 867 F.2d 489 (9th Cir. 1988), *cert. denied*, 492 U.S. 906 (1989); *Donovan* v. *Dillingham*, 688 F.2d 1367.

[4] *Taggert Corporation* v. *Life and Health Benefits Administration, Inc.*, 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 459 U.S. 851, *reh'g denied*, 459 U.S. 1059 (1982); *Gahn* v. *Allstate Life Ins. Co.*, 926 F.2d 1449 (5th Cir. 1991).

they can attract the attention of the Secretary of Labor, if they don't lose heart first or die first, if they prevail and secure their remedy under ERISA, they win only what they were entitled to all along under the contract of insurance—the payment of the claim. Thus, if state bad faith law [5] is preempted under 29 U.S.C. § 1132, there is nothing under this scheme to discourage insurance carriers from denying potentially expensive claims such as chronic disease, cancer and AIDS, and attempting to pass the burden of these claims off on other health care systems, generally those supported by the taxpayers. With this much at stake, the distinction which Congress so carefully drew between employee "benefits" and employee benefit "plans" in setting forth the scope of ERISA preemption should not be readily blurred.

Since Congress intended that ERISA only preempt state laws relating to employee benefit plans and not those with relate merely to employee benefits (*Fort Halifax*, 482 U.S. at 7), distinguishing between the two becomes critical to implementing the intention of the Congress. In the view of these Petitioners, the Court has already defined the basis for such a distinction in *Fort Halifax*. Certainly prior to this Court's decision in *Fort Halifax*, there was some considerable confusion in distinguishing between the two when the employee benefit was provided by means of an insurance policy.

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[5] Well established law in California provides a cause of action in tort, permitting consequential damages, against an insurer which in bad faith denies an insured's claim under a policy. *Fletcher* v. *Western Nat. Life Ins. Co.*, 10 Cal.App.3d 376, 89 Cal.Rptr. 78 (1970); *Silberg* v. *California Life Ins. Co.*, 11 Cal.3d 452, 113 Cal. Rptr. 711, 521 P.2d 1103 (1974). At least 33 states recognize an insured's right to consequential damages (and in some circumstances, punitive damages) in an action at law on account of an insurer's wrongful delay or refusal to pay claims. *Insurer's Liability for Consequential or Punitive Damage for Wrongful Delay or Refusal to Make Payments Under Contract*, 47 A.L.R.3d 314 (1973).

Early on, the Fifth Circuit had focused in such a situation on the employer's relationship with the insurance program to determine whether an employer established or maintained a plan when it provided benefits by means of insurance; specifically, it focused on the employer's commitment to the ongoing provision of the benefit. *Taggert Corporation* v. *Life and Health Administration, Inc.*, 671 F.2d 1208. In that case, Taggert Corporation purchased a health insurance policy for its sole employee from a multi-employer trust. The Fifth Circuit held that the trust itself, a for-profit, proprietary enterprise established for the purpose of marketing the insurance policies to employers, was not an appropriate party to confer ERISA jurisdiction. *Id.* at 1210. The court specifically rejected a suggestion by the Secretary of Labor that Taggert's subscription to the trust by itself established an ERISA plan. "Considering the history, structure and purposes of ERISA, we cannot believe that that Act regulates bare purchases of health insurance where, as here, the purchasing employer neither directly not directly owns, controls, administers or assumes responsibility for the policy or its benefits." *Id.* at 1211.

Subsequently, but still before this Court's decision in *Fort Halifax*, the 11th Circuit, decided that the appropriate focus should be on the provisions of the insurance policy itself. The Eleventh Circuit also rejected as "sweeping too broadly" the Secretary of Labor's suggestion that an employer's decision to provide the type of benefits described in the ERISA legislation is sufficient to establish an employee benefit plan. *Donovan* v. *Dillingham*, 688 F.8d at 1373. "[T]he purchase of insurance does not conclusively establish a plan . . . but the purchase is evidence of the establishment of a plan. . . ." *Id.* Rather, the court ruled that in determining whether the purchase of an insurance policy constituted establishing and maintaining an employee benefit plan, it should focus on the policy itself, and "whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for re-

ceiving benefits." *Id.* As Justice Mosk pointed out in the California Supreme Court, this can hardly be a basis for differentiation as it is difficult to conceive of an insurance policy that would not meet this test. *See* App. A at 22a.

This Court's decision in *Fort Halifax* established that the focus properly belongs on the nature of the employer's activity in connection with the insurance program, not on the policy. In *Fort Halifax*, as noted, the Court drew a distinction between an employee benefit and an employee benefit plan, and demonstrated that because of the plain language of the ERISA preemption provision, the purpose of that provision, and the overall objectives of ERISA itself, state laws could only be preempted where they related to an employee benefit plan. *Fort Halifax*, 482 U.S. at 7. The Court reasoned that this is so because ERISA's preemption provisions were intended to insulate employers from inconsistent regulation of the complex administrative activities associated with employee benefit plans. *Id.* at 11.

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. *Id.* at 9.

On the other hand, the Court observed, where the employer engages in none of these activities in connection with providing an employee benefit (as was the case with Miller Imports in the instant matter) none of the concerns which the ERISA preemption was intended to address are present, and therefore there is no preemption. In the Court's view, it was the assumption by an employer of these myriad responsibilities which defines an employee benefit plan.

> Congress intended pre-emption to afford employers the advantages of a uniform set of administrative procedures governed by a single set of regulations. This concern only arises, however, with respect to benefits whose provision by nature requires an ongoing administrative program to meet the employer's obligation. It is for this reason that Congress pre-empted state laws relating to *plans*, rather than simply to *benefits*. Only a plan embodies a set of administrative practices vulnerable to the burden that would be imposed by a patchwork scheme of regulation.

Id. at 11-12.

Regrettably, confusion remains: does *any* program which provides benefits of the type described in ERISA and which requires ongoing administrative activity constitute a "plan" or does only a program of benefits described in ERISA which requires ongoing administrative activity *by an employer* constitute a "plan"? The answer is the latter. "Only 'plans' involve administrative activity potentially subject to employer abuse." *Id.* at 16. Certainly, the dissenting justices in *Fort Halifax* read the majority decision that way. "I dissent because it is incredible to believe that Congress intended that the broad preemption provision contained in ERISA would depend upon the extent to which an employer exercised administrative foresight in preparing for the eventual payment of employee benefits." *Id.* at 23 (White, J., dissenting).

Thus, in *Fort Halifax*, this Court established that the appropriate way to determine whether an employer established and maintained an employee benefit plan is to focus on the degree and nature of the employer's activity and commitment in the provision of that benefit. However, *Fort Halifax* has not found consistent application in cases in which the employee benefit is provided by means of an insurance policy. Because *Fort Halifax* did not involve insurance, and because it involved obligations for one-time, rather than ongoing, payment of

benefits, application of this Court's holding to the most common types of insurance arrangements, such as that exemplified in the instant case, remains inconsistent. Conflict remains among the federal Circuits in applying the holding of *Fort Halifax* where employers provide benefits through insurance. Similarly, the two highest state courts which have addressed the issue have reached conflicting results.

Notwithstanding this Court's guidance in *Fort Halifax*, several circuits have adopted the approach of the Eleventh Circuit in *Donovan* v. *Dillingham* and continue to examine the issue from the perspective of the insurance policy rather than from the perspective of the employer's relationship to the benefit program. The *Dillingham* approach was endorsed by the Sixth Circuit in *International Resources* v. *New York Life*, 950 F.2d 294.

The Fifth Circuit, however, continues to focus on the employer's role. In *Memorial Hosp. System* v. *Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990), the court held that the purchase of insurance by an employer which paid one-half of employees' premiums was more than a "bare bones" purchase of insurance because the employer assumed sole responsibility for paying premiums monthly, and thus showed the "intent to provide its employees with a welfare benefit program through the purchase and maintenance of a group health insurance policy." *Id.* at 241. The court noted that the complaint had alleged that the employer had "administered and maintained" the policy and had engaged in conduct constituting the handling of insurance matters in connection with the policy pursuant to Texas insurance law. *Id.* at 243 n.8. The court distinguished its earlier decision in *Taggert* on the basis that *Taggert* involved only a bare purchase of insurance, while in *Memorial Hosp.*, the employer had engaged in activities consistent with an intent to "administer the plan as well as insure it." *Id.* at 242-243.

The Fifth Circuit subsequently underscored its view that the determination of the issue should be from the perspective of the employer's role in providing the insurance benefit rather than from the perspective of whether the elements of the statutory definition of an employee benefit plan could be gleaned from the insurance policy itself in *Gahn* v. *Allstate Life Ins. Co.*, 926 F.2d 1449. There, the Fifth Circuit, reversing the district court, found that the purchase from a multi-employer trust of a health insurance policy by a gift shop owner to cover himself and his employees (who were his wife and children) did not constitute the establishment of an employee benefit plan. The Fifth Circuit held that the district court had improperly focused on the activity of the multi-employer trust, and that to determine whether the purchase of the policy constituted the establishment and maintenance of a "plan" the court "should have focused on the employer . . . and his involvement with the administration of the plan." *Id.* at 1452. The court remanded the matter for factual determinations relevant to this examination, noting that the only factual record (the employer's affidavit that he played no part in formulation of policy, held no monies in trust, but merely forwarded premiums to the carrier and did not own, control or administer the policy and had no responsibility for benefits) suggested that the policy was not an ERISA plan. *Id.* at 1452-1453. Thus, while in both the *Memorial Hosp.* and *Gahn* decisions the Fifth Circuit, paying lip service to *Dillingham*, said the determination should involve examination of the circumstances to see if the elements of an ERISA plan are present, it is clear from both decisions that the Fifth Circuit's examination of the question remains focussed on the employer's activities in relation to the provision of the benefit.

Thus, two threads of reasoning have been established in the federal circuit courts in determining whether an employer establishes and maintains an employee benefit

plan when it provides benefits of the type described in ERISA by purchasing an insurance policy. Some circuits follow the lead of the Eleventh Circuit and focus on the insurance policy itself, to determine whether the "elements" of an employee benefit can be read from the policy. The Fifth Circuit has followed the lead of this Court, and focuses on the activities of the employer and its relation to the provision of and continuation of benefits. The same indecision has been demonstrated by the state courts.

While the Supreme Court of California has following the *Dillingham* approach, the Supreme Court of Nevada has reached the opposite result in a substantively identical case. *Turnbow* v. *Pacific Mutual Life Ins. Co.*, 765 P.2d 1160. In *Turnbow*, the employer purchased health benefits insurance from a multi-employer trust, paying the premiums for herself and her three full-time employees. Starting from the premise that more than the mere purchase of insurance is necessary to establish a "plan", the Nevada Supreme Court determined that no ERISA plan was created because there was no indication of employer commitment to continue such benefits.

This uncertainty in how to determine if an employer establishes an employee benefit plan by purchasing an insurance policy and performing, at best, ministerial functions in connection with that policy, as reflected by the conflict in decisional authority both in the federal courts of appeal and among the state supreme courts which have considered the issue, complicates the assertion and protection of the rights of insured employees. The rights of millions of insureds are at stake. And because, as noted, the remedies under ERISA for bad faith by carriers are so limited, and correspondingly, the potential for abuse so great, at stake, ultimately, is the question of who will pay potentially billions of dollars of health care costs.

CONCLUSION

For these various reasons, the Petition for Certiorari should be granted.

Respectfully submitted,

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APPENDICES

APPENDIX A

IN THE SUPREME COURT
OF THE STATE OF CALIFORNIA

S022055
(Ct. of Appeal No. B050259)
(Sup. Ct. No. C544301)

LINDA BROWN MARSHALL *et al.*,
Plaintiffs and Appellants,

v.

BANKERS LIFE AND CASUALTY COMPANY *et al.*,
Defendants and Respondents.

[Filed July 9, 1992]

We granted review in this case to determine whether an employer that purchases a group health insurance policy to cover its employees and their dependents, but whose involvement in administration of benefits under the policy is minimal, thereby establishes an "employee benefit plan" within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. § 1001 et seq.), so that an action seeking damages under state law for the denial of a claim for policy benefits is preempted by federal law.[1] We conclude that an employee benefit plan is established on these facts despite

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[1] See 29 United States Code sections 1002(1) (definition of "employee welfare benefit plan"), 1144(a) (supersedure of state laws relating to employee benefit plans).

the employer's minimal involvement in plan administration and complete noninvolvement in claims processing. An action seeking remedies under state law for an improper denial of benefits is, therefore, preempted. (*Pilot Life Ins. Co.* v. *Dedeaux* (1987) 481 U.S. 41, 47-57; *Commercial Life Ins. Co.* v. *Superior Court* (1988), 47 Cal.3d 473, 484-485.)

BACKGROUND

In 1983 Donald Marshall was employed by Miller Import Datsun, Inc. (Miller Import). Miller Import's employee manual stated that all employees would be provided with group health insurance coverage. From March 1, 1983, to October 1, 1983, Miller Import provided its employees with health insurance coverage under a group health, life, and disability insurance policy issued by Bankers Life and Casualty Company (Bankers) and administered by Frank B. Hall & Company of California/MIA Administrators (Hall/MIA). All of Miller Import's employees were covered under the policy. Miller Import allowed its employees to enroll their dependents for coverage under the group policy, and Donald Marshall enrolled his wife, Linda. Miller Import paid the entire cost of premiums for its employees. It also paid the cost of premiums for covered dependents and then deducted those amounts from employees' paychecks. Hall/MIA billed Miller Import for premiums on a monthly basis.

Miller Import's role in administration of the policy was minor. It directed its employees to fill out enrollment cards and forms for changes of beneficiaries and dependent coverage; it then submitted the completed cards to Hall/MIA. Miller Import received, and distributed to its employees, booklets entitled "Your Group Insurance Plan," containing information about the policy and procedures for filing claims. Additionally, Miller Import gave its employees copies of a three-page letter, prepared by Hall/MIA, explaining coverage under the policy. Miller Import provided its employees with claim forms, which they

or their health care providers submitted directly to Hall/MIA. Miller Import neither reviewed nor evaluated claim forms; Hall/MIA made all determinations regarding eligibility for medical benefits. Miller Import employees were asked to contact Hall/MIA with any questions regarding the policy. However, when employees occasionally asked questions regarding enrollment, coverage changes, and claims, Miller Import personnel would try to respond before contacting Hall/MIA.

Miller Import did not intend to create an ERISA-governed benefit plan, and never filed any reports with the United States Department of Labor with respect to its group insurance policy.

The present suit arose out of the denial of Linda Marshall's claim for medical benefits. The operative pleading (the fourth amended complaint) alleged that Linda Marshall suffered aftereffects of an aneurysm and brain surgery, requiring hospitalization, during the term of the Bankers policy. Although Hall/MIA confirmed coverage under the policy at the time of her hopitalization, coverage was later revoked and her claims for benefits were denied on the basis that her claim related to a preexisting condition, sickle-cell anemia. The Marshalls sued Bankers and Hall/MIA, alleging breach of the duty of good faith and fair dealing, fraud, intentional infliction of emotional distress, negligence, and violation of Insurance Code section 790.03. Defendants denied liability. Both sides moved unsuccessfully for summary judgment on the issue of whether ERISA preempted the Marshalls' action. (29 U.S.C. § 1144(a).) That issue was bifurcated for trial on stipulated facts as set forth in the preceding three paragraphs.

The trial court ruled that Miller Import's insurance program constituted an "employee welfare benefit plan" within the meaning of ERISA, so that the Marshalls' claims were preempted. Accordingly, it entered judgment for defendants. The Court of Appeal reversed, holding

that because there was no administrative activity potentially subject to employer abuse, ERISA was not implicated. For the reasons that follow, we conclude the Court of Appeal erred in focusing on the employer's involvement in administration of policy benefits.

ANALYSIS

ERISA is a comprehensive federal law designed to promote the interests of employees and their beneficiaries in employee pension and benefit plans. (*Shaw* v. *Delta Air Lines, Inc.* (1983) 463 U.S. 85, 90.) As a part of this integrated regulatory system, Congress enacted various safeguards to preclude abuse and to secure the rights and expectations that ERISA brought into being. (29 U.S.C. § 1001; see also Sen. Rep. No. 93-127, 1st Sess., p. 36 (1973).) Prominent among these safeguards is an expansive preemption provision, found at section 514 of ERISA (29 U.S.C. § 1144; *Ingersoll-Rand* v. *McClendon* (1990) 498 U.S. ——, —— [112 L.Ed.2d 474, 482-483]; *Carpenters So. Cal. Admin. Corp.* v. *El Capitan Development Co.* (1991) 53 Cal.3d 1041, 1047.)

ERISA's preemption clause is conspicuous for its breadth, establishing as an area of exclusive federal concern the subject of every State law that "relates to" an employee benefit plan governed by ERISA. (*FMC Corp.* v. *Holliday* (1990) 498 U.S. ——, —— [112 L.Ed.2d 356, 364].) ERISA preempts "any and all State laws insofar as they . . . relate to any employee benefit plan," except laws "which regulate insurance . . . ." (29 U.S.C. § 1144(a), (b)(2)(A).) An employee benefit plan is not deemed to be an insurance company or other insurer, or to be engaged in the business of insurance, for purposes of any state law purporting to regulate insurance companies or insurance contracts. (29 U.S.C. § 1144(b)(2)(B).)

In *Pilot Life Ins. Co.* v. *Dedeaux*, *supra*, 481 U.S. 41, the high court held that ERISA preempts state common

law tort and contract actions based on an insurer's improper processing of a claim for benefits under an insured employee benefit plan because such actions "relate to" an employee benefit plan, and because the state common law of tort and contract does not "regulate insurance" within the intent of ERISA. (*Id.* at pp. 47-57.) In *Commercial Life Ins. Co.* v. *Superior Court, supra,* 47 Cal.3d 473, we held that ERISA preempts a surviving private cause of action brought under California Insurance Code section 790.03, subdivision (h), when the action asserts a claim arising from an employee benefit plan. (47 Cal.3d at p. 484; see *Moradi-Shalal* v. *Firemen's Fund Ins. Companies* (1988) 46 Cal.3d 287 [prospectively eliminating private causes of action under Ins. Code, § 790.03, subd. (h)].) Clearly, *Pilot Life* and *Commercial Life* require us to conclude that all of the Marshalls' causes of action are preempted if the group health plan under which Linda Marshall filed a claim for benefits is an employee benefit plan governed by ERISA. We turn accordingly to that question.[2]

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[2] Although the United States Supreme Court has not addressed the question expressly, it has assumed that employer-sponsored group insurance plans are ERISA plans. In *Pilot Life,* as in this case, the employer purchased a group disability insurance policy, collected and matched its employees' contributions to the plan and forwarded premiums to the insurer; the employer also provided claim forms to its employees and forwarded the completed forms to the insurer, which bore the responsibility of determining who would receive benefits. (*Pilot Life Ins. Co.* v. *Dedeaux, supra,* 481 U.S. at p. 43.) Similarly, in *Commercial Life* the employer sponsored an insured medical benefit plan for its employees; the plaintiff employee forwarded his medical bills to the insurer for payment; and the insurer refused payment, denying coverage. (*Commercial Life Ins. Co.* v. *Superior Court, supra,* 47 Cal.3d at p. 475.) In neither case is there any indication that the employer took a role in the processing of claims. The Marshalls do not attempt to draw any factual distinctions between this case, on one hand, and *Pilot Life* and *Commercial Life,* on the other. However, *Pilot Life* did not explicitly address the requirements of an ERISA plan, and in *Commercial Life* the parties did not dispute that the plan was of

ERISA governs any employee benefit plan established or maintained by an employer engaged in commerce or in an industry or activity affecting commerce. (29 U.S.C. § 1003(a).) An "employee welfare benefit plan," within the meaning of ERISA, is "any plan, fund, or program . . . established or maintained by an employer . . . to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) *medical, surgical, or hospital care or benefits*, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services. . . ." (29 U.S.C. § 1002(1), emphasis added.)

The existence of an ERISA plan is a question of fact, to be answered in light of all of the surrounding circumstances as viewed by a reasonable person. (*Kanne* v. *Connecticut General Life Ins. Co.* (9th Cir. 1988) 867 F.2d 489, 492.) The burden is on defendants to prove facts necessary to establish the defense of ERISA preemption. (*Id.* at p. 492, fn. 4.)

The Marshalls contend that Miller Import did not establish an employee benefit plan under ERISA when it purchased the Bankers policy, arguing that there is no employee benefit plan unless the employer is involved in the plan's administration. Initially, we must observe that the statutory language does not support such a requirement. Instead, ERISA applies when an employer "*establishes* or *maintains*" a plan for the purpose of providing its employees and their dependents with medical benefits. (29 U.S.C. § 1002(1), emphasis added.) The

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the type regulated by ERISA. Appellate courts in this state and in the federal system have in a number of cases articulated tests for determining whether a given arrangement constitutes an employee benefit plan within the contemplation of ERISA. We are now called upon to do the same.

statute expressly contemplates the purchase of insurance as a possible means of providing those benefits. (*Ibid.*) ERISA's definition of "administrator" covers a person so designated by the terms of the instrument under which the plan is operated, who may be someone other than the employer sponsoring the plan. (29 U.S.C. § 1002 (16)(A); see also 29 U.S.C. §§ 1102(b)(2) [plan must describe any procedure for allocation of responsibilities for operation and administration of plan], 1105(c) [plan instrument may provide for procedures to allocate fiduciary responsibilities among named fiduciaries and may provide for named fiduciaires to designate others to carry out fiduciary responsibilities under plan].) In addition, the United States Department of Labor's regulations implementing ERISA contemplate that benefits under an insured employee-welfare-benefit plan may be administered by an insurance company or service. (29 C.F.R. § 2560.503-1(c), (g)(2) (1984).) Finally, we note that holders of group insurance policies commonly do not bear primary responsibility for processing claims. That function is generally either retained by the insurer of delegated to a third party administrator, as in this case. Thus, considerations founded in the statute, implementing regulations, and common practice militate against the argument advanced by the Marshalls.

Fort Halifax Packing Co. v. *Coyne* (1987) 482 U.S. 1 (*Fort Halifax*), on which the Marshalls rely, does not support a contrary conclusion. *Fort Halifax* was an action to enforce rights under a Maine statute requiring employers to make a one-time severance payment to employees in the event of a plant closing. (Me. Rev. Stat. Ann., tit. 26, § 625-B.) The employer asserted ERISA preemption as a defense against the action. The high court held that the Maine statute was not preempted by ERISA "because the statute neither establishes, nor requires an employer to maintain, an employee welfare benefit 'plan' under that federal statute." (*Fort Halifax, supra*, 482 U.S. at p. 6.) The high court reasoned that

"[t]he requirement of a one-time, lump-sum payment triggered by a single event requires no administrative scheme whatsoever to meet the employer's obligation. . . . The theoretical possibility of a one-time obligation in the future simply creates no need for an ongoing administrative program for processing claims and paying benefits." (*Id.* at p. 12.) ERISA's regulatory concerns are implicated only when there is ongoing administrative activity subject to abuse. When delivery of a benefit requires no administrative scheme—as with the nonrecurring severance payment at issue in *Fort Halifax*—then ERISA's interest in ensuring national uniformity of regulation is not implicated. When a continuing administrative scheme is required, on the other hand, ERISA's preemption provision eliminates the threat of conflicting and inconsistent state and local regulation. (*Id.* at p. 9.)

Fort Halifax, *supra*, 482 U.S. 1, dealt with a benefit payable directly by an employer, not pursuant to an insurance policy. Consequently, the high court had no occasion to address the situation of an employer that chooses to provide its employees with a benefit through the mechanism of a group insurance policy administered by the insurer or another person so designated. Its reference to the "employer's obligation" must be read in the light of its facts. Properly understood, *Fort Halifax* requires us to consider not the level of the *employer's* participation in an ongoing administrative program, but rather whether such a program exists at all.[3]

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[3] The Marshalls urge that *Gahn* v. *Allstate Life Ins. Co.* (5th Cir. 1991) 926 F.2d 1449 dictates a contrary rule. We cannot agree. *Gahn* was a suit arising out of an alleged wrongful termination of coverage under a group health insurance policy. The plaintiff was an employee of her husband's business; he purchased the insurance to cover himself and his employees (his wife and their two sons). Defendant Allstate provided the insurance through a multiple employer trust. In determining whether an employee welfare benefit plan was established on these facts, the district court focused on the relationship between Allstate and the trust. The court of appeals held that focus to be erroneous, noting that the

While a plan is not established merely by the employer's deciding to have one, the plan need not be in writing in order to exist. (*James* v. *National Business Systems, Inc.* (7th Cir. 1991) 924 F.2d 718, 720.) To hold that a plan exists, the court must be able to determine "whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits." (*Donovan* v. *Dillingham, supra*, 688 F.2d 1367, 1373 [en banc]; see also *Brown* v. *Ampco-Pittsburgh Corp.* (6th Cir. 1989) 876 F.2d 546, 551 [adopting *Dillingham* test]; *Ed. Miniat, Inc.* v. *Globe Life Ins. Group, Inc.* (7th Cir. 1986) 805 F.2d 732, 739 [same]; *Harris* v. *Arkansas Book Co.* (8th Cir. 1986) 794 F.2d 358, 360 [same]; *Scott* v. *Gulf Oil Corp.* (9th Cir. 1985) 754 F.2d 1499, 1503-1504 [same].) These criteria are easily met in this case. A reasonable person would conclude that the intended benefits were the payment of medical and hospitalization expenses under the group insurance policy Miller Import purchased; the beneficiaries were Miller Import's employees and covered dependents; the source of financing was the premiums paid by Miller Import and the employees; and the procedure

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trust itself was not established or maintained by an employer and was therefore not an employee welfare benefit plan. (*Id.* at p. 1452.)

In the case before us, the Marshalls focus on the *Gahn* court's statement that the district court should have looked to "the employer, Mr. Gahn, and his involvement with the administration of the plan." (*Gahn* v. *Allstate Life Ins. Co., supra*, 926 F.2d at p. 1452.) Despite the quoted language, the court of appeals did *not* consider whether it was Mr. Gahn's responsibility to process claims under the policy. Rather, the court employed the tests formulated in *Donovan* v. *Dillingham* (11th Cir. 1982) 688 F.2d 1367, 1373, and in the Department of Labor's safe-harbor regulation (29 C.F.R. § 2510.3-1(j)), discussed *post* at pages ——-—— (typed maj. opn. at pp. 12-13), and concluded the record was insufficient to enable it to determine whether Mr. Gahn's group health plan was an employee benefit plan. *Gahn* does not, therefore, stand for the proposition that an employer must administer a benefit plan in order for ERISA to apply.

for receiving benefits was the submission to Hall/MIA of claim forms procured from Miller Import. (*Hansen* v. *Continental Ins. Co.* (5th Cir. 1991) 940 F.2d 971, 977.)

Having concluded that a "plan" exists, we must determine whether it is an *ERISA* plan. (*Hansen* v. *Continental Ins. Co., supra*, 940 F.2d at p. 977.) An ERISA plan is one established or maintained by the employer with the purpose of providing its employees with any of the types of benefits specified in ERISA. (See 29 U.S.C. § 1002(1) ["medical, surgical, or hospital care or benefits"].) There is no dispute that the hospitalization benefits Linda Marshall sought fall within the enumerated categories of benefits.

The remaining question, then, is whether Miller Import "established or maintained" the plan in order to provide its employees with medical or hospitalization benefits. No single act in itself necessarily constitutes the establishment of a plan (*Donovan* v. *Dillingham, supra*, 688 F.2d at p. 1373), but an employer can establish an ERISA plan "rather easily." (*Credit Managers Ass'n* v. *Kennesaw Life & Acc. Ins.* (9th Cir. 1987) 809 F.2d 617, 625.) The Court of Appeals for the Ninth Circuit has noted in dicta that "[e]ven if an employer does no more than arrange for a 'group-type insurance program,' it can establish an ERISA plan, unless it is a mere advertiser who makes no contributions on behalf of its employees." (*Ibid.*, citing 29 C.F.R. § 2510.3-1(j) (1975).) The United States Department of Labor has promulgated a regulation excluding group insurance programs from ERISA's definition of "employee benefit plan" when: (1) the employer makes no contributions toward premiums; (2) participation is completely voluntary for employees; (3) the employer's sole functions are, without endorsing the program, to allow the insurer to publicize it to employees, to collect premiums through payroll deductions, and to remit them to the insurer; and (4) the employer receives no consideration in connection with the program

other than reasonable compensation for administrative services rendered in connection with the payroll deductions. (29 C.F.R. § 2510.3-1(j).) All four conditions must be present in order for the plan to fall outside ERISA (*Kidder* v. *H & B Marine, Inc.* (5th Cir. 1991) 932 F.2d 347, 351), although as the Court of Appeals for the Seventh Circuit has pointed out, "in creating a safe harbor [the regulation] does not automatically invalidate all arrangements on the high seas." (*Brundage-Peterson* v. *Compcare Health Services Ins.* (7th Cir. 1989) 877 F.2d 509, 511; see also 29 C.F.R. § 2510.3-1(a)(4) (1975) [safe-harbor regulation should not be read as indicating Department of Labor's view of possible scope of "employee welfare plan" under ERISA].) Because Miller Import paid the premiums for its employees' coverage, the regulation undercuts rather than supports the Marshalls' position.

A "bare purchase" of insurance—one meeting the conditions set forth in the Department of Labor's regulation, with no employer endorsement or involvement other than deducting premiums from employees' paychecks and forwarding them to the insurer—does not conclusively establish the existence of an ERISA plan. (*Kanne* v. *Connecticut General Life Ins. Co., supra*, 867 F.2d at p. 492.) However, a purchase of insurance is evidence of the establishment of a plan, and the purchase of a policy covering a class of employees offers substantial evidence that the employer has established a plan. (*Donovan* v. *Dillingham, supra*, 688 F.2d at p. 1373.)

The Marshalls rely on *Taggart Corp.* v. *Life & Health Benefits Admin.* (5th Cir. 1980) 617 F.2d 1208, 1211, certiorari denied 450 U.S. 1030, for the proposition that an employer must administer benefits under a group insurance policy in order for ERISA to apply. However, in a case decided after *Taggart*, the Court of Appeals for the Fifth Circuit rejected the contention that *Taggart* held an employer's purchase of an insurance policy to be

outside the scope of ERISA. (*Memorial Hosp. System* v. *Northbrook Life Ins. Co.* (5th Cir. 1990) 904 F.2d 236, 241-242.) The court emphasized that *Taggart* involved a claim by a corporation and its only employee that a multiple employer trust (MET) constituted an ERISA plan; the corporation, through its president and sole employee, subscribed to the MET in order to obtain health care for the president and his family at reduced premiums. The corporation and its president sued under ERISA to recover benefits allegedly owing the president's wife. The United States District Court dismissed for lack of subject matter jurisdiction, concluding the evidence showed the transaction simply involved a purchase of insurance by the plaintiff for himself and his family. (See *Taggert Corp.* v. *Efros* (S.D.Tex. 1979) 475 F.Supp. 124, 127.) The Court of Appeals affirmed, holding that neither the MET nor the corporation's subscription to its constituted an ERISA plan. The court reasoned that the corporation did no more than make payments to a purveyor of insurance, evidently for tax reasons. (*Taggart Corp.* v. *Life & Health Benefits Admin.*, *supra*, 617 F.2d at p. 1211; *cf.* 29 C.F.R. § 2510.3-3(b), (c)(1) [plans without employees are not governed by ERISA; an individual and his or her spouse shall not be deemed employees of a business, whether incorporated or unincorporated, that is wholly owned by the individual or by the individual and the spouse].) *Taggart*, therefore, does not avail the Marshalls.

Miller Import did more than make a "bare purchase" of insurance. It selected the Bankers policy from among other available policies, choosing to provide health care benefits to all of its employees at its own cost, and to provide the opportunity for its employees to enroll their dependents in the group plan. Miller Import paid monthly premiums, submitted enrollment cards and forms for changes of beneficiary to Hall/MIA, and cancelled the Bankers policy after six months' time, substituting

another group policy purchased from a different insurer. Miller Import's actions demonstrated beyond peradventure that it established and maintained the policy. The fact that Miller Import's administrative functions under the policy are minimal is perfectly in keeping with its intent that Hall/MIA administer the plan that Bankers insured. (See *Memorial Hosp. System* v. *Northbrook Life Ins. Co.*, *supra*, 904 F.2d at pp. 242-243.) Delegation of plan administration is a common feature of employee benefit plans, one contemplated, as we have seen, by ERISA. (*Brundage-Peterson* v. *Compcare Health Services Ins.*, *supra*, 877 F.2d at p. 511; see 29 U.S.C. §§ 1002(16)(A), 1102(b)(2), 1105(c); see also 29 C.F.R. § 2560.503-1(c), (g)(2).) Such a delegation in no way precludes the establishment or maintenance of an ERISA plan.

We conclude that an employer that—in order to provide its employees with any of the benefits specified in ERISA—purchases a group insurance policy, contributes toward premiums and remits them to the insurer, and retains authority to terminate the policy or change its terms has "established or maintained" an ERISA plan regardless of whether it also processes claims or otherwise administers the policy. (See also *International Resources* v. *New York Life Ins.* (6th Cir. 1991) 950 F.2d 294, 297-298 [applying *Donovan* and *Brundage* analyses to find ERISA plan on similar facts].)

Our conclusion is consistent with the views of the United States Department of Labor. In a 1976 interpretive opinion, the department took the position that an ERISA plan is created in an arrangement whereby the employer purchases a group insurance policy providing life, accident, and health benefits and contributes the entire cost of premiums for employees, with employees contributing the cost of premiums for covered dependents through payroll deductions. (U.S. Dept. Labor, ERISA Opn. Letter 76-06 (April 30, 1976).) The department's reasonable views, while not binding on us, are entitled

to deference. (*Massachusetts* v. *Morash* (1989) 490 U.S. 107, 116.)

Language in several decisions by California Courts of Appeal can be read to suggest that employer involvement in the administration of policy benefits is necessary in order to trigger the application of ERISA. In *Rizzi* v. *Blue Cross of So. California* (1988) 206 Cal.App.3d 380 (*Rizzi*), the first of these decisions, the court relied on *Fort Halifax, supra*, 482 U.S. 1, to declare that ERISA's concern with regulating the administrative integrity of a program arises when an employer provides benefits in a way that requires the employer's administration of funds. The *Rizzi* court stated that "[t]he ultimate determination depends on an evaluation of all the circumstances, keeping in mind ERISA's purpose of regulating an *employer's administration* of benefit plans." (206 Cal.App.3d at p. 390, emphasis in original; see also *Lambert* v. *Pacific Mutual Life Ins. Co.* (1989) 211 Cal.App.3d 456, 463-465 [applying similar analysis].)

As the court in *Hughes* v. *Blue Cross of Northern California* (1989) 215 Cal.App.3d 832 recognized, however, *Rizzi*'s language must be read in light of its actual holding: affirmance of summary judgment dismissing an action on the ground of ERISA preemption "on a showing only that the employer procured the group insurance policy for the benefit of its employees, maintained control over amendment or termination of the policy, and performed certain incidental services, such as transmission of subscription charges and notices." (*Id.* at pp. 854-855.)

Rizzi, supra, 206 Cal.App.3d 380, as the court below and the parties seem to agree, involved facts virtually indistinguishable from those in this case. Unlike the court below, we believe *Rizzi* correctly held the employee's action preempted. *Rizzi's* emphasis on the employer's administration of the program, however, predicated on an overexpansive reading of *Fort Halifax, supra*, 482 U.S. 1, does not accurately reflect the law.

Our conclusion that Miller Import established and maintained a plan under ERISA is not altered by the fact that Miller Import neither complied with ERISA's requirements nor intend to create an ERISA plan. (*Scott* v. *Gulf Oil Corp.*, *supra*, 754 F.2d at pp. 1503-1504; see also *Firestone Tire & Rubber Co.* v. *Bruch* (1989) 489 U.S. 101, 105 [claims under termination pay plan, established by employer unaware of ERISA's applicability and requirements, adjudicated under ERISA].) The test of whether a benefit plan is exempt from ERISA is not one of the employer's motivation. (*Shaw* v. *Delta Air Lines, Inc.*, *supra*, 463 U.S. at p. 107.) An employer cannot "opt out" of ERISA by noncompliance.

For the first time on appeal, the Marshalls assert that defendants are equitably estopped to raise preemption as a defense. Assuming, without deciding, that the doctrine of estoppel might in an appropriate case be applied to avoid ERISA preemption,[4] we decline to address the issue in the absence of a fully developed record. Although the Marshalls refer to evidence that the defendants failed to disclose that the plan was governed by ERISA, they cite no evidence establishing that defendants were aware either that the policy was subject to ERISA or that ERISA would preclude the Marshalls from asserting state law causes of action. Nor do they cite evidence to support their contention that they relied on defendants' conduct to their injury. (See *Ellenburg* v. *Brockway* (9th Cir. 1985) 763 F.2d 1091, 1096 [prerequisites to application of equitable estoppel].) Additionally, defendants suggest

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[4] The Marshalls cite a number of cases in support of their estoppel argument, but none is apposite; the cases hold that a defendant may be estopped to deny coverage under ERISA of benefits promised in a plan, not that a defendant may be estopped to raise the defense of ERISA preemption in an action under state law. (*Davidian* v. *Southern California Meat Cutters Union* (9th Cir. 1988) 859 F.2d 134, 136; *Dockray* v. *Phelps Dodge Corp.* (9th Cir. 1986) 801 F.2d 1149, 1155; see also *Black* v. *TIC Investment Corp.* (7th Cir. 1990) 900 F.2d 112, 114-115.)

that it was Miller Import's conduct, if anyone's that might give rise to an estoppel. (See 29 U.S.C. §§ 1002(16)(A), (B) [plan "administrator" defined as person so designated under plan's governing instrument; absent specific designation, administrator is plan's sponsor, the employer], 1021, 1024 [administrator's filing, reporting, and disclosure duties].) These unsettled factual issues and insufficiently briefed legal arguments render this an inappropriate case in which to depart from the ordinary rule limiting an appellate decision to issues the parties raised below. (See *Panopluos* v. *Maderis* (1956) 47 Cal. 2d 337, 340-341; *Blatt* v. *Farley* (1990) 226 Cal.App.3d 621, 627.)

The Marshalls urge that when neither the employer purchasing the group insurance policy covering its employees nor the insurer or administrator of the policy complies with ERISA requirements, ERISA's objectives are not served by preemption of state law remedies. We cannot agree. Although failure to comply with ERISA's reporting requirements may subject the responsible fiduciaries to statutory penalties and liability for relief (see 29 U.S.C. §§ 1109, 1132(c)(2)), it does not deprive employees of their right to sue under ERISA to secure their benefits. (*Blau* v. *Del Monte Corp.* (9th Cir. 1984) 748 F.2d 1348, 1352; 29 U.S.C. § 1132(a)(1)(B).) Congress has clearly expressed its intent that the civil enforcement provisions of ERISA be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of claims for benefits. (*Commercial Life Ins. Co.* v. *Superior Court*, *supra*, 47 Cal.3d at p. 480.) ERISA's enforcement scheme carefully balances the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law

that Congress rejected in ERISA. (*Pilot Life Ins. Co.* v. *Dedeaux, supra,* 481 U.S. at p. 54.)

DISPOSITION

The judgment of the Court of Appeal is reversed.

PANELLI, J.

WE CONCUR:

LUCAS, C.J.
KENNARD, J.
ARABIAN, J.
BAXTER, J.
GEORGE, J.

DISSENTING OPINION BY MOSK, J.

I dissent. The majority misinterpret the holding of *Fort Halifax Packing Co.* v. *Coyne* (1987) 482 U.S. 1 (hereinafter *Fort Halifax*), as well as other cases permitting preemption of state law by the Employee Retirement Income Security Act (ERISA) only if the employer takes a substantial role in administering an insurance policy. Moreover, their conclusion that the employer in this case "established and maintained" an "employee benefit plan" is based on reasoning inconsistent on the face of the opinion.

In analyzing the preemption issue, it must be kept in mind the "basic assumption [is] that Congress did not intend to displace state law." (*Maryland* v. *Louisiana* (1981) 451 U.S. 725, 746.) The presumption applies most strongly where, as here, Congress legislates in an area traditionally occupied by the states (*Rice* v. *Santa Fe Elevator Corp.* (1947) 331 U.S. 218, 230), such as tort law. Since there is a strong presumption against preemption, we should not, as the majority do, read the provisions of ERISA expansively, so as to enlarge the scope of its preemption language.

Fort Halifax (*supra*, 482 U.S. 1) is directly contrary to the majority's holding. In distinguishing that case, the majority rely on the fact that the severance payment there involved was made directly by the employer to the employee, rather than pursuant to an insurance policy. However, the rationale of that case cannot be so easily dismissed. Almost the entire analysis in the opinion relates to the purpose served by the preemption provisions of ERISA and the reason why that purpose is not violated unless the employer performs such administrative tasks as the calculation and payment of benefits pursuant to an "employee benefit plan."

The opinion in *Fort Halifax* provides three reasons in support of its conclusion that the Maine statute requiring

payment of severance benefits in that case was not preempted by ERISA. First, ERISA does not preempt state laws that grant employee benefits, but only those that relate to an "employee benefit plan." (482 U.S. at p. 8.) A payment to an employee that does not require ongoing administrative activity by the employer is not such a plan.

Second, one reason only an "employee benefit plan" is subject to preemption is that an employer who administers such a plan would be subject to state regulation, raising the prospect of a conflict between ERISA and state regulation. That is, an employer-administered plan would require the employer to perform functions like determining the eligibility of claimants and calculating benefit levels. The most efficient way to meet these obligations is to provide a set of standard procedures to guide the processing of claims and disbursement of benefits. This conduct would be subject to state regulatory requirements, thereby interfering with ERISA's goal of assuring that administrative practices of a benefit plan will be governed by a single set of regulations. (*Fort Halifax, supra*, 482 U.S. at pp. 8-14.)

Third, the statute was not preempted by ERISA because the severance payment did not implicate a second concern of the preemption provision, namely, the regulatory purposes of ERISA. The fiduciary standards contained in the federal legislation were designed to safeguard employees who were the beneficiaries of an "employee benefit plan" from such abuses by an employer as self-dealing, imprudent investment, and misappropriation of plan funds. "Only 'plans' involve administrative activity potentially subject to employer abuse." (*Fort Halifax, supra*, 482 U.S. at p. 16.) Without such activity by the employer, "[i]t would make no sense for preemption to clear the way for exclusive federal regulation, for there would be nothing to regulate." (*Ibid.*)

In sum, *Fort Halifax* holds that state laws are not preempted by ERISA unless the employer administers an

"employee benefit plan," because it is only such administration that would violate the dual purpose of the preemption provision, i.e., the avoidance of conflict between state and federal regulations governing administration of the plan, and the danger that the employer might abuse its administrative function.

The dissenting opinion in *Fort Halifax* also understands the majority as holding that the issue of preemption turns on whether the employer has established an "administrative scheme" for paying benefits. ("I dissent because it is incredible to believe that Congress intended that the broad preemption provision contained in ERISA would depend upon the extent to which an employer exercised administrative foresight in preparing for the eventual payment of employee benefits." (*Fort Halifax, supra*, 482 U.S. 1, 23, dis. opn. of White, J.)

The majority in the instant case barely mention the high court's reasoning in *Fort Halifax*. Instead, they attempt to distinguish the decision on the ground that the employer there paid the severance benefit directly to the employee. This attempted distinction is patently invalid. The reason the severance payment in that case did not invoke preemption, as the court expressly stated, was because it did not require administration by the employer; it was not, as the majority here claim, because the payment was made directly to the employee by the employer. ("Some severance benefit obligations by their nature necessitate an ongoing administrative scheme, but others do not. Those that do not, such as the obligation imposed in this case, simply do not involve a state law that 'relate[s] to' an employee benefit 'plan.'" (*Fort Halifax, supra*, 482 U.S. at p. 18.)

If anything, direct payment by the employer is more likely to indicate preemption under the Supreme Court's rationale than indirect payment, such as payment by an insurer. The court describes the type of activities of an employer that will invoke federal preemption, as follows:

Preemption occurs if the employer "makes a commitment systematically *to pay certain benefits*" by undertaking such activities as "determining the eligibility of claimants, calculating benefit levels, *making disbursements* . . . and keeping appropriate records in order to comply with applicable reporting requirements." (*Fort Halifax, supra,* 482 U.S. at p. 9, italics added.) Thus, the employer who pays the employee directly is, under the Supreme Court's analysis, more involved in administration of a benefit plan and therefore more likely to invoke preemption than one who pays a benefit only by purchasing a policy of insurance.

No case, so far as I am aware, has interpreted the holding of *Fort Halifax* as being confined merely to cases in which the employer made direct payment to the employee, nor is there any authority for the proposition that employer administration of a policy is irrelevant to the issue of preemption. A number of cases following the high court's decision have properly viewed it as standing for the proposition that an employer's involvement in plan administration is the touchstone of the preemption analysis. (*Gahn* v. *Allstate Life Ins. Co.* (5th Cir. 1991) 926 F.2d 1449, 1452 [although the court ultimately concluded that the record was insufficient to enable it to decide whether a benefit plan was involved, the principle that the employer's "involvement with the administration of the plan" is the determining factor in the preemption analysis was clearly stated]; *Taggart Corp.* v. *Life & Health Benefits Admin.* (5th Cir. 1980) 617 F.2d 1208, 1210-1211; *Turnbow* v. *Pacific Mut. Life Ins. Co.* (Nev. 1988) 765 P.2d 1160, 1161; *Lambert* v. *Pacific Mutual Life Ins. Co.* (1989) 211 Cal.App.3d 456, 463-465; *Rizzi* v. *Blue Cross of So. California* (1988) 206 Cal.App.3d 380, 389 ["the line of demarcation between ERISA plans and non-ERISA plans depends on the level of involvement by the employer in the program so as to warrant federal regulation of the administrative integrity of the program"].)

Furthermore, the majority's reasoning is inconsistent on its face. While it concedes that the mere purchase of insurance does not establish a plan, it effectively holds that preemption occurs if the employer does no more than make such a purchase. Thus, it concludes that a plan exists if a "reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits." I fail to see how an employer can purchase any insurance without the specification of these details.

The majority's conclusion that the employer in this case did more than merely purchase insurance suffers from the same defect. Its conclusion is based on the following factors: The employer (1) selected the policy from among other available policies, (2) chose to provide health care benefits to all of its employees at its own cost and to provide the opportunity for dependent coverage, (3) paid the monthly premiums, (4) submitted enrollment cards and forms for changes of beneficiary to the administrator, and (5) cancelled the policy after six months and substituted another policy from a different insurer. Aside from number 4 on this list, an employer who makes a "bare purchase" of insurance must perform all these tasks, assuming that it has the power to cancel the policy, as the employer had in this case.[1] That is, the employer cannot purchase insurance without choosing a policy and paying the premiums. Only the fact that the employer submitted enrollment and change of beneficiary forms to the insurer's administrator goes beyond "mere purchase." The notion that an insurer is totally immunized from liability under state law because the employer rather than the employee transmits these routine forms to the insurer is incomprehensible.

The same problem with the majority's reasoning is evident in its conclusion that the employer "established

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[1] The fact that the employer was not obligated to continue to provide health benefits weighs against preemption. (*Donovan* v. *Dillingham* (11th Cir. 1982) 684 F.2d 1367, 1374-1375.)

and maintained" an ERISA plan because it purchased a group insurance policy, contributed to premiums and remitted them to the insurer, and retained the authority to terminate it. How can an employer purchase a policy without complying with these requirements?

Today's decision deprives countless Californians defrauded by insurers of the protection afforded by state law. It is ironic indeed that a federal statute designed to defend the interests of insured employees is construed to sanction such a result. Sadly, it bears repeating, as stated in my dissent in *Garvey* v. *State Farm Fire & Casualty Co.* (1989) 48 Cal.3d 395, 416, "in this court, the insurer wins and the insureds lose."

I would affirm the judgment of the Court of Appeal.

MOSK, J.

APPENDIX B

IN THE COURT OF APPEAL
OF THE STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT
DIVISION THREE

2d Civil No. B050259

(Super. Ct. No. C544301)

LINDA BROWN MARSHALL,
DONALD MARSHALL,
Plaintiffs and Appellants,

v.

BANKERS LIFE AND CASUALTY COMPANY, *et al.*,
Defendants and Respondents.

[Filed June 10, 1991]

APPEAL from a judgment of the Superior Court of Los Angeles County. Norman L. Epstein, Judge. Reversed.

Greene, Broillet, Taylor & Wheeler, Randy McMurray and Timothy J. Wheeler; Mandell, Lewis & Goldberg and Michael L. Goldberg, for Plaintiffs and Appellants.

O'Neal & Wodin and Marc J. Wodin, for Defendants and Respondents.

Plaintiffs and appellants Linda Brown Marshall and Donald Marshall appeal a judgment in favor of defendants and respondents Bankers Life and Casualty Company (Bankers) and Frank B. Hall and Company of California (EBH), (collectively, defendants).

The issue presented is whether the Marshalls' action arising out of an employment-based group health insurance program is preempted by ERISA.[1]

SUMMARY STATEMENT

The purpose of ERISA is to protect employees from potential abuses as a result of *employer* involvement in the administration of benefit plans. Employee insurance benefits which are not provided through such plans are outside the contemplation of ERISA and are governed by California common law and statutory law. Insurance companies which merely contract with employers for employee health benefits cannot hide behind nonexistent ERISA plans to avoid California bad faith actions.

Due to the focus of ERISA, preemption thereunder turns on the extent to which the employer is involved in the administration of a benefit program so as to implicate the concerns which gave rise to ERISA. Here, there was no administrative activity potentially subject to employer abuse so that ERISA's concern with regulating the administrative integrity of the program was not implicated. The judgment is therefore reversed.

FACTUAL AND PROCEDURAL BACKGROUND

After commencing the action on April 23, 1985, the Marshalls filed the operative pleading, a fourth amended complaint, on May 23, 1986, naming Bankers; FBH; and MIA Administrators, a subsidiary of FBH.

The plaintiffs alleged: Defendants had failed and refused to pay certain medical benefits allegedly due them

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[1] Employment Retirement Income Security Act (29 U.S.C. section 1001 et seq.).

under a group health insurance policy issued by Bankers to Donald Marshall's employer, Miller Import Datsun, Inc. (Miller), with respect to the hospitalization and treatment of Donald Marshall's wife, Linda Marshall, from May 5, 1983 to June 20, 1983. Defendants had denied the claim on the ground her hospitalization was for preexisting sickle-cell anemia, and under the policy, preexisting conditions were allowed a maximum benefit of $1,000. However, Linda Marshall was not being treated for sickle-cell anemia but for aftereffects of an aneurysm and brain surgery, and these facts were known to defendants.

The Marshalls pled six causes of action against Bankers, the insurer, as well as FBH, the administrator appointed by Bankers, as follows: (1) breach of the duty of good faith and fair dealing; (2) fraud (against Bankers); (3) fraud (against FBH); (4) breach of statutory duties (Ins. Code, § 790.03); (5) intentional infliction of emotional distress and willful and wanton misconduct; and (6) negligence.

The thirteenth affirmative defense of defendants' answer asserted that all causes of action were preempted by ERISA. Thereafter, both sides unsuccessfully sought summary judgment on the preemption issue, and the matter proceeded to trial before the court without a jury.

The trial court bifurcated the issue of ERISA preemption and tried the matter on stipulated facts.

a. *Contents of the stipulation.*

The stipulation consisted of 24 defendants' facts and 25 plaintiffs' facts. It established the following:

Bankers approved Miller's application for a group health insurance policy, and coverage was in effect from March 1, 1983, to October 1, 1983. Miller received no compensation or consideration from Bankers for the subject insurance policy. Miller provided this coverage,

which included health, life and disability insurance, to all its employees as part of an employee benefit package. Donald Marshall, as a Miller employee, was enrolled as an insured, while Linda Marshall was enrolled for dependent coverage.

While Miller's employee manual stated all employees would be provided with group health insurance coverage, Miller was not required to provide any health insurance to its employees pursuant to any written contract or collective bargaining agreement. Miller had the authority and the right at any time to cancel the subject group insurance policy and eventually it did so.

While the policy was in effect, Miller was billed by FBH and paid the premiums on a monthly basis out of Miller's own account. Miller did not set aside a separate fund for payment of the premiums. Miller paid the premiums for its employees in their entirety. Miller also paid the premiums for covered dependents, such as Linda Marshall, but deducted the amount of dependents' premiums from the employees' paychecks.

Miller was provided with enrollment cards and change forms, which it provided to its employees, and then sent the completed forms to FBH. Miller did nothing with completed enrollment cards or change forms, other than to forward them to FBH and to insert a copy in the employees' files.

Miller added or deleted names or employees who were hired or terminated and sent those changes to FBH. FBH or Bankers had all responsibility for determining whether an employee or dependents were eligible for coverage. FBH calculated and made all adjustments to Miller's premiums.

Miller also was provided with claim forms which it passed on to its employees. All completed claim forms were submitted directly by the employee or health care provider to FBH. FBH had been appointed by Bankers

as its agent to administer the plan and FBH processed all claims. Miller did not review the completed claim forms and had no responsibility for evaluating claims which had been submitted. Nor was Miller responsible for monitoring how much money was available for paying claims. Miller could not deny any benefits under the policy. Benefits were paid directly to the employee or to the health care provider at the employee's request. Miller never handled the funds used to pay benefits and had no opportunity to misappropriate or improvidently invest those funds.

Miller also was provided with informational booklets, as well as a three-page explanatory letter, which it distributed to its employees. FBH sometimes sent information to Miller's employees via Miller. Occasionally, FBH requested Miller to have employees complete various forms, and Miller provided the employees with the forms.

Personnel at Miller would attempt to respond to employees' insurance questions which arose. If Miller could not resolve the problem, it would contact FBH or place the employee in contact with FBH. FBH directed Miller to have its employees contact FBH regarding benefits or claims. Donald Marshall spoke with FBH personnel regarding policy questions. He never spoke with anyone at Miller regarding the subject insurance.

Miller did not intend to create an ERISA plan. Donald Marshall was never informed his rights and obligations under the policy were governed by ERISA, and he was never told the insurance was to be an ERISA plan. Miller never filed any reports with the Department of Labor with respect to the subject insurance policy. Miller had no offices or employees outside California.

b. *Trial court's ruling.*

Following argument by counsel, the matter was taken under submission. Thereafter, the trial court held:

The employer's involvement in the program was "not extensive." There was no evidence Miller specifically intended to establish a program that would be covered by ERISA. But, the program which was established was for ongoing benefits of the type typically covered by ERISA. The employer paid employees' premiums, although the employees paid the cost of dependent coverage. The employer had the power to terminate the plan. The employer collected dependent premiums and transmitted those funds. The employer also performed various administrative duties such as disseminating insurance pamphlets to employees, handling enrollment forms and changes, answering questions and forwarding some questions to FBH and assisting in claims processing.[2] The employer did not handle money received by FBH, nor disburse benefits, nor make decisions regarding coverage or benefit payments on claims.

Despite the employer's limited involvement, the trial court felt bound by California authority to hold the Marshalls' action was barred. It concluded: "While the employer's involvement is not extensive, application of the ERISA standards to these facts, under established precedent (see *Rizzi* v. *Blue Cross of So. California* . . . and cases cited; *Hughes* v. *Blue Cross of No. California* . . . leads to the conclusion that the involvement is sufficient to establish the benefit program as an ERISA plan. [¶] . . . [P]laintiffs' causes of action are therefore preempted[.]"

The Marshalls appealed.

CONTENTIONS

The Marshalls contend there is insufficient evidence to support the finding the subject health insurance policy was an ERISA "plan." The employer's involvement in

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[2] The finding that the employer assisted in claims processing is unsupported by the stipulation.

administering the program was limited and ministerial and therefore did not implicate the purpose of ERISA.

DISCUSSION

1. *General ERISA principles.*

ERISA, which is found at 29 United States Code section 1001 et seq., in the chapter entitled Employee Retirement Income Security Program, "comprehensively regulates employee pension and welfare plans." (*Metropolitan Life Ins. Co.* v. *Massachusetts* (1985) 471 U.S. 724, 732 [85 L.Ed.2d 728]; 29 U.S.C. §§ 1002, 1003.)

The congressional findings and declaration of policy underlying ERISA are set forth in 29 United States Code section 1001. This section recognizes the proliferation of employee benefit plans, certain abuses resulting in employee loss of retirement benefits, and the need for Congress to establish certain minimal standards to assure "the equitable character of such plans and their financial soundness." (29 U.S.C. § 1001, subd. (a).)

The general objective of this legislation was to increase the number of individuals in employer-financed benefit plans and to "'assure that those who do participate actually receive benefits and do not lose benefits as a result of unduly restrictive forfeiture provisions or failure of the pension plan to retain sufficient funds to meet its obligations.' [1974] U.S.Code Cong. & Admin.News pp. 4676-77." (*In re C. D. Moyer Co. Trust Fund* (E.D. Pa. 1977) 441 F.Supp. 1128, 1131, affd. without pub. opn. (3d Cir. 1978) 582 F.2d 1273, 1275.)

The act "protects interstate commerce and the participants of employee benefit plans by requiring disclosure to participants, establishing standards of conduct and fiduciary duties, and providing for remedies, sanctions, and ready access to federal courts. (29 U.S.C. § 1001(b).)" (*Commercial Life Ins. Co.* v. *Superior Court* (1988) 47

Cal.3d 473, 476; see *Pilot Life Ins. Co.* v. *Dedeaux* (1987) 481 U.S. 41, 44 [95 L.Ed.2d 39].)

ERISA contains a broad preemption provision which states that with certain exceptions, its provisions "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." (29 U.S.C. § 1144(a).)[3] The preemptive aspect of ERISA protects employers from conflicting and inconsistent state and local regulation of employee benefit plans. (*Shaw* v. *Delta Air Lines, Inc.* (1983) 463 U.S. 85, 99 [77 L.Ed.2d 490]; *Fort Halifax Packing Co.* v. *Coyne* (1987) 482 U.S. 1, 10 [96 L.Ed.2d 1].) "In analyzing whether ERISA's preemption is applicable . . . , ' "the purpose of Congress is the ultimate touchstone." ' " (*Fort Halifax Packing Co., supra,* at p. 8.)

ERISA only preempts state laws relating to "employee benefit *plans*", not all state legislation regarding employee benefits. (*Fort Halifax Packing Co.* v. *Coyne, supra,* 482 U.S. at pp. 7-8.) 29 United States Code section 1002(1) defines an " 'employee welfare benefit plan' " as "any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, [or] death . . . ." The Act "does not further define 'plan, fund, or program.' " (*Massachusetts* v. *Morash* (1989) 490 U.S. 107, 114 [104 L.Ed.2d 98].)

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[3] ERISA preempts private causes of action under Insurance Code section 790.03, subdivision (h), as to those cases which survive *Moradi-Shalal* v. *Fireman's Fund Ins. Companies* (1988) 46 Cal.3d 287. (*Commercial Life Ins. Co., supra,* 47 Cal.3d at pp. 484-485.)

a. *ERISA plan is a question of fact.*

The existence of an ERISA plan "is a question of fact, to be answered in light of all the surrounding facts and circumstances from the point of view of a reasonable person." (*Kanne* v. *Connecticut General Life Ins. Co.* (9th Cir. 1988) 867 F.2d 489, 492.)

The presumption is against preemption and it is a defendant's burden to prove the facts necessary to establishing an ERISA defense. (*Elsworth* v. *Beech Aircraft Corp.* (1984) 37 Cal.3d 540, 548; *Kanne, supra,* 867 F.2d at p. 492, fn. 4; *Metropolitan Life Ins. Co.* v. *Massachusetts, supra,* 471 U.S. at p. 741.)

Here, defendants argue Miller's plan is an ERISA plan within the meaning of section 1002 because it is (1) a plan, fund or program, (2) established or maintained (3) by an employer (4) for the purpose of providing medical, surgical or hospital care benefits (5) to participants or their beneficiaries. (*Donovan* v. *Dillingham* (11th Cir. 1982) 688 F.2d 1367, 1371.) However, merely to repeat the language of the statute in its application to this fact situation begs the question.

2. *The administrative scheme test as to what constitutes a plan.*

Section 2510.3-1(j), 29 Code of Federal Regulations, a Department of Labor regulation, states an ERISA plan does not exist if, inter alia, no contributions are made by the employer.[4] However, it does not necessarily follow

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[4] The regulation states no ERISA plan exists if: "(1) No contributions are made by an employer or employee organization; [¶] (2) Participation [sic] the program is completely voluntary for employees or members; [¶] (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and [¶] (4) The employer or employee organization re-

that the mere payment of premiums by an employer is sufficient to give rise to an ERISA plan. (*Lambert* v. *Pacific Mutual Life Ins. Co.* (1989) 211 Cal.App.3d 456, 464.) "A bare purchase of insurance, . . . , does not by itself constitute an ERISA plan (although it may be evidence of the existence of an ERISA plan)." (*Kanne* v. *Connecticut General Life Ins. Co.*, *supra*, 867 F.2d at p. 492.)

In *Fort Halifax Packing Co.* v. *Coyne*, *supra*, 482 U.S. 1, the United States Supreme Court considered whether a Maine statute requiring an employer to provide a one-time severance payment to employees in the event of a plant closing was preempted by ERISA.

Fort Halifax observed: "It is . . . clear that ERISA's pre-emption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities." (*Fort Halifax Packing Co.*, *supra*, 482 U.S. at p. 11.) An employer that "makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in different States." (*Id.*, at p. 9.)

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ceives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs." (29 C.F.R. § 2510-3-1(j) (1990).)

The court held the Maine statute was not preempted because it "neither establishes, nor requires an employer to maintain, an employee benefit *plan*" under ERISA. (*Fort Halifax Packing Co., supra*, 482 U.S. at p. 12.) The requirement of a one-time severance payment did not create a "need for an ongoing administrative program for processing claims and paying benefits." (*Ibid.*) As a result, the Maine statute did not "[create] the potential for the type of conflicting regulation of benefit plans that ERISA pre-emption was intended to prevent. [Fn. omitted.]" (*Id.*, at p. 14.)

Further, not only did the Maine statute fail to implicate the concerns of ERISA's preemption provision, but it also failed to implicate the regulatory concerns of ERISA itself. (*Fort Halifax Packing Co., supra*, 482 U.S. at p. 15.) As indicated, ERISA was enacted because Congress found it desirable that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of employee benefit plans. (*Ibid.*) ERISA's fiduciary standards were intended to prevent abuses of the special responsibilities borne by those dealing with such plans, and to shield employees from employer self-dealing, imprudent investing, and misappropriation of plan funds. (*Ibid.*) "The focus of [ERISA] thus is on the administrative integrity of benefit plans—which presumes that some type of administrative activity is taking place." (*Ibid.*) Where there is no "plan" involving administrative activity potentially subject to employer abuse, preemption does not serve the overall purpose of ERISA. (*Id.*, at p. 16.)[5] [6]

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[5] The dissenting opinion in *Fort Halifax* criticized the majority's rule making preemption turn on the existence of an administrative scheme. (*Fort Halifax Packing Co., supra*, 482 U.S. at p. 23.) It urged the characterization of certain employee benefits as nonadministrative would undermine Congress' intent to make employee benefit plans a matter of exclusive federal regulation. (*Ibid.*)

[6] See also the pre-*Fort Halifax* case of *Drummond* v. *McDonald Corp.* (1985) 167 Cal.App.3d 428, 432, wherein an ERISA plan

Since *Fort Halifax*, the United States Supreme Court again has addressed the issue of employer involvement in benefit administration. In *Massachusetts* v. *Morash*, *supra*, 490 U.S. at page 109, the court considered the application of ERISA to a company's policy of paying discharged employees for their unused vacation time. It observed the distinguishing feature of most benefit plans is that "they accumulate over a period of time and are payable only upon the occurrence of a contingency outside of the control of the employee." (*Id.*, at pp. 115-116.) The court held the company's policy did not constitute an employee welfare benefit plan, noting "Congress' primary concern [in enacting ERISA] was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds." (*Id.*, at p. 115.)

Thus, under federal statutory and decisional law, the existence of an employee benefit plan subject to preemption under ERISA depends on the extent to which an employer is involved in the administration of the benefit program so as to implicate the concerns which gave rise to ERISA.[7]

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existed where the employer processed claims and performed other administrative functions.

[7] Although the employer in *Pilot Life* paid disability insurance premiums and forwarded completed claim forms to the insurer, which processed the claims, the issue addressed in that case was whether ERISA preempts state common law tort and contract actions asserting improper processing of claims made under an insured employee benefit plan. (*Pilot Life Ins. Co., supra*, 481 U.S. at p. 43.) The *existence* of an ERISA-regulated plan was not addressed and apparently, simply was assumed.

Similarly, in *Metropolitan Life Ins. Co.* v. *Taylor* (1987) 481 U.S. 58, 60 [95 L.Ed.2d 55], the first paragraph of Part I simply states the employer "set up an employee benefit plan subject to the provisions of ERISA for its salaried employees."

3. *California appellate developments.*

a. *The Rizzi decision.*

In *Rizzi* v. *Blue Cross of So. California* (1988) 206 Cal.App.3d 380, 382, an employee insured under his employer's group health policy brought an action against the insurer, alleging, inter alia, violation of Insurance Code section 790.03 in the denial of his claim for benefits. *Rizzi* affirmed a grant of summary judgment in favor of the insurer due to ERISA preemption.

While acknowledging that *Fort Halifax* arose in a different factual context, the *Rizzi* court recognized the import of that decision. *Rizzi* stated: "Applying by analogy the *Fort Halifax* analysis here, the line of demarcation between ERISA plans and non-ERISA plans depends on the level of involvement by the employer in the program so as to warrant federal regulation of the administrative integrity of the program. That is, when employers provide benefits to employees in a manner which involves the employer's administration of funds to be used for the employees, ERISA's concern with regulating the administrative integrity of the program arises. This in turn supports characterizing [a] program as an ERISA 'plan.'" (*Rizzi* v. *Blue Cross of So. California*, *supra*, 206 Cal.App.3d at p. 389.)

After summarizing the evidence presented in the case before it, *Rizzi* concluded: "We are satisfied . . . that the employer contributed to the insurance premiums. In light of that fact in context with the form of *the Blue Cross plan showing other employer controls over operation of the program*, Blue Cross carried its burden at the summary judgment hearing to establish the existence of an ERISA plan." (*Rizzi*, *supra*, 206 Cal.App.3d at p. 391, italics added.)

The plan under consideration in *Rizzi* required the employer to pay monthly to Blue Cross, in advance, all subscription charges of its subscribers, i.e. eligible em-

ployees. If the employer failed to pay any installment, the agreement would terminate without notice. If the subscriber ceased to be employed by the employer, his or her certificate would terminate, but the the subscriber was entitled to apply for a conversion privilege. If Blue Cross or the employer terminated the agreement, then individual certificates would be terminated without any conversion privilege. Blue Cross could not cancel any individual certificate, and, any notice required of Blue Cross would be deemed sufficient if mailed to the employer. (*Rizzi, supra*, 206 Cal.App.3d at pp. 390-391.)

Nothing in the recitation of this evidence supports *Rizzi*'s conclusion of "other employer controls over operation of the program" in addition to payment of subscription charges. (*Rizzi, supra*, 206 Cal.App.3d at p. 391.) The employer's role in *Rizzi* essentially was limited to paying the monthly premiums. The fact the employer purchased the policy, could control the termination of the policy, and passed along various notices, does not amount to *employer administration* of a benefit plan.

If such slight involvement were sufficient to invoke ERISA, *every* garden variety employee health insurance benefit program would fall within ERISA and would subject the paying employer, large or small, to ERISA's regulatory burdens. *Rizzi*'s overbroad reading would require all these employers to choose between the statute's detailed requirements for reporting and disclosure or discontinuing their health insurance benefits. (See *Massachusetts* v. *Morash, supra*, 490 U.S. at p. 118.)

While the *Fort Halifax* dissent would support *Rizzi*'s sweeping approach to preemption (*Fort Halifax Packing Co., supra*, 482 U.S. at p. 23), the *controlling* opinion in *Fort Halifax* rejected such an approach in favor of an administrative scheme test based upon actual employer involvement (*id.*, at p. 12). The *Rizzi* court could not enlarge the scope of preemption under federal law. Thus, while *Rizzi*'s recitation of *Fort Halifax* is accurate,

Rizzi's application of those principles to its fact situation is wrong and we respectfully decline to follow it.[8]

b. *Further relevant cases.*

Lambert v. *Pacific Mutual Life Ins. Co., supra,* 211 Cal.App.3d 456, similarly involved the issue of employer administration of a health insurance program. In *Lambert,* the employer secured medical insurance coverage for its employees by subscribing to the Multi-Protection Trust which provided a group insurance plan underwritten by Pacific Mutual. The employees did not pay premiums for employee coverage but did contribute for dependent coverage. The agreement and application form indicated the Pacific Mutual plan was subject to ERISA, and that the undersigned employer was the named fiduciary for the plan. The employer provided the employee with a certificate booklet which complied with ERISA summary plan description requirements, including a statement of the employee's rights under ERISA, and identified the employer as the plan administrator. (*Id.,* at pp. 458-460.)

Thus, in addition to employer payment of premiums, evidence established the Multi-Protection Trust intended to create an ERISA plan and promoted it as such, and the employer, as the designated plan administrator and fiduciary, had endorsed the plan. The fact the employer's president was unfamiliar with ERISA or its obligations under ERISA incident to the plan, did not refute the endorsement. Based thereon, *Lambert* found "sufficient employer involvement and administration under *Fort Halifax* to bring the . . . plan within [ERISA] . . . ." (*Lambert, supra,* 211 Cal.App.3d at p. 465.)

Similarly, in *Faria* v. *Northwestern National Life Ins. Co.* (1989) 216 Cal.App.3d 1129, 1135-1137, contribu-

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[8] *Rizzi* also erroneously refers to the substantial evidence standard in reviewing a summary judgment. (*Rizzi, supra,* 206 Cal. App.3d at p. 382; *Stratton* v. *First Nat. Life Ins. Co.* (1989) 210 Cal.App.3d 1071, 1083.)

tions were made by the employer toward group medical coverage, the employer tacitly endorsed the plan, and the booklet given to employees named a plan administrator and described the insured's rights under ERISA, so as to bring the plan within ERISA.[9]

Hughes v. *Blue Cross of Northern California* (1989) 215 Cal.App.3d 832, likewise was presented with the issue of employer involvement in the administration of group health insurance so as to implicate ERISA. (*Id.*, at pp. 854-855.) An insured brought an action against her insurer for denial of benefits for her son's hospitalization and obtained an $850,000 verdict. (*Id.*, at p. 838.) The insurer raised the issue of federal preemption under ERISA for the first time on appeal. (*Id.*, at p. 848.)

After reviewing *Fort Halifax* and *Rizzi*, *Hughes* "surmise[d] from the sparse record that the agreement very probably is a welfare benefit plan[.]" (*Hughes*, *supra*, 215 Cal.App.3d at p. 859.) However, that portion of the decision is mere dictum because *Hughes* affirmed the judgment on procedural grounds. *Hughes* observed the insured had lacked notice of the preemption defense and an opportunity to refute it at trial, and because the issue did not involve subject matter jurisdiction but merely raised a choice of law question, a remand for a further hearing on the issue was unwarranted. (*Id.*, at p. 859.)

With this overview, we examine the facts of the instant case.

4. *Miller did not establish an administrative scheme so as to implicate ERISA.*

a. *Standard of appellate review.*

As indicated, the existence of an ERISA plan is a factual question, to be determined in light of all the sur-

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[9] See also *Rogers* v. *Prudential Ins. Co.* (1990) 218 Cal.App.3d 1132, 1137-1139, wherein summary judgment was precluded due to a factual dispute as to whether the employer paid the group insurance plan premiums.

rounding facts and circumstances from the point of view of a reasonable person. (*Kanne* v. *Connecticut General Life Ins. Co.*, *supra*, 867 F.2d at p. 492.)

Where a judgment is founded upon stipulated facts, with no conflict in the evidence or question of credibility of witnesses, the issue becomes one of law which can be resolved by an appellate court as well as a trial court. (*Oliver & Williams Elevator Corp.* v. *State Bd. of Equalization* (1975) 48 Cal.App.3d 890, 894; 9 Witkin, Cal. Procedure (3d ed. 1985) Appeal, § 291, p. 303.)

This principle is limited by the rule of conflicting inferences. Even where the facts are undisputed, if conflicting inferences reasonably may be drawn therefrom, the trier of fact's conclusion must be accepted by the reviewing court. (*Mah See* v. *North American Acc. Ins. Co.* (1923) 190 Cal. 421, 426, overruled on other grounds in *Zuckerman* v. *Underwriters at Lloyd's* (1954) 42 Cal.2d 460, 474; *McKinney* v. *Kull* (1981) 118 Cal.App. 3d 951, 955-956; *Fullerton Union High School Dist.* v. *Riles* (1983) 139 Cal.App.3d 369, 383; 9 Witkin, *supra*, § 288, p. 300.) However, if only one reasonable inference can be drawn from the evidence, the question is one of law and the appellate court is not bound by the trial court's determination. (*State of California* v. *Superior Court* (1962) 208 Cal.App.2d 659, 665; *Fullerton Union High School Dist.*, *supra*, 139 Cal.App.3d at p. 383; 9 Witkin, *supra*, § 289, pp. 301-302.)

These principles govern our review of this case.

b. *Only reasonable inference to be drawn from uncontroverted evidence is that Miller did not establish a "plan."*

The uncontroverted evidence establishes none of the *Fort Halifax* criteria for an ERISA plan are present. What we have here is a "bare purchase of insurance" (*Kanne*, *supra*, 867 F.2d at p. 492), and a temporary one at that.

As indicated, while Miller's employee manual stated that all employees would be provided with group health insurance coverage, Miller was not required to provide any health insurance to its employees by any written contract or collective bargaining agreement. Further, Miller had the authority and the right to cancel the subject group insurance policy and eventually it did so. Thus, it cannot be said that Miller had made a "commitment systematically to pay [these] benefits . . . ." (*Fort Halifax Packing Co.* v. *Coyne*, *supra*, 482 U.S. at p. 9.)

In addition, the eligibility of claimants was determined by FBH or Bankers, not by Miller. (See *Fort Halifax Packing Co.*, *supra*, 482 U.S. at p. 9.) Similarly, FBH processed all claims—Miller was not positioned to calculate benefit levels or to deny benefits under the policy. (*Ibid.*) Further, all funds were disbursed directly from the insurer to the employee or the employee's health care provider, without any handling by Miller. (*Ibid.*) Also, Miller had no responsibility for monitoring the availability of funds for benefit payments. (*Ibid.*) Lastly, it does not appear that Miller assumed the burden of keeping appropriate records in order to comply with any applicable reporting requirements. (*Ibid.*)

In sum, Miller's role was limited to paying the policy premiums and performing ministerial tasks such as dispensing enrollment and change forms, claim forms and informational material. Admittedly, *Fort Halifax* is distinguishable in that only a single set of severance payments was involved, while here, Miller regularly paid premiums over a period of months. Nonetheless, as the United States Supreme Court held in *Fort Halifax Packing Co.*, *supra*, 482 U.S. at page 12: "To do little more than write a check hardly constitutes the operation of a benefit plan. [Fn. omitted.]"

Further, due to the lack here of any compliance with formal ERISA requirements, *Lambert* and *Faria* are unavailing to defendants. In those cases, there was an

intent to create an ERISA plan, and the plan was promoted or endorsed as such. In *Lambert*, the participating employer was designated the plan administrator, and the certificate booklet complied with ERISA summary plan description requirements and included a statement of the employee's rights under ERISA. (*Lambert, supra*, 211 Cal.App.3d at pp. 460, 465.) Similarly, in *Faria*, there was an in-house plan administrator, and the summary plan description apprised the employees of their ERISA rights. (*Faria, supra*, 216 Cal.App.3d at pp. 1135-1137.)

Here, in contrast, Miller did not intend to create an ERISA plan, no reports were filed with the Department of Labor regarding Miller's health insurance benefit program, and Donald Marshall was never advised his rights and obligations under the policy were governed by ERISA or that this was to be an ERISA plan.

We recognize an employer's failure to meet ERISA's requirements for establishing a plan (i.e., written instrument, named fiduciaries, public reports), does not exempt a benefit plan from coverage by ERISA. Were it otherwise, employers could escape ERISA's coverage merely by failing to comply with its formal administrative and reporting requirements. (*Scott* v. *Gulf Oil Corp.* (9th Cir. 1985) 754 F.2d 1499, 1503, disagreed with on other grounds by *Lee* v. *E.I. DuPont de Nemours and Co.* (5th Cir. 1990) 894 F.2d 755, 757.)

Here, however, not only is there no formal compliance with ERISA, there is not even employer involvement in benefit administration. Without employer means of affecting "the equitable character of [ERISA] plans and their financial soundness" (29 U.S.C. § 1001, subd. (a)), the ERISA scheme cannot be invoked by insurance companies solely as a means of resisting an employee's state law claims.

Finally, we cannot avoid the context in which this issue comes before us. An employer which, without any intent to create an ERISA plan, simply purchased a group

health policy for its employees. Yet the insurer now seeks to elevate that fact to a level sufficient to enable the insurer to avoid liability for its alleged bad faith conduct in the handling of claims arising under that policy. In short, the insurer seeks the protection of a federal regulatory scheme without any evidence that any of the purposes or concerns, which Congress had when it enacted that regulatory scheme, were in any way implicated. Although Miller's employees had none of the protections or benefits of a bona-fide ERISA plan, the insurer now seeks to use the illusion of such a plan to deprive them of the benefits of state laws regulating insurer misconduct.

CONCLUSION

The purpose of Congress is the "'"ultimate touchstone"'" in determining preemption under ERISA (*Fort Halifax Packing Co., supra*, 482 U.S. at p. 8), and ERISA's focus is on the "administrative integrity of benefit plans" (*id.*, at p. 15).

ERISA's essential purpose is to protect employees from potential abuses, such as misappropriation of funds, stemming from *employer* administration of benefit *plans*. The purpose of the preemption provision is to protect employers from potentially inconsistent state regulations. (*Fort Halifax Packing Co., supra*, 482 U.S. at pp. 11, 15.) Where there is neither an employer administrative scheme, nor any accumulation of benefits, nor any intent to create a plan under ERISA, neither concern of ERISA is implicated. Thus, ERISA does not preempt California common law and statutory law with respect to ordinary employee insurance benefits.

The mere payment by an employer of premiums for employee health insurance is insufficient to constitute a plan governed by ERISA. Otherwise, all employer-paid health benefits would fall within ERISA's ambit, contrary

to Congress' intent to preempt solely the regulation of benefit *plans*, and not all employee benefits.[10]

Here, defendants failed to meet their burden of establishing the facts to show preemption. The uncontroverted evidence reveals there was no uniformed "plan" subject to ERISA, and the employer's role essentially was limited to paying the policy premiums and taking care of minor ministerial details. This limited obligation of the employer did not generate administrative activity potentially subject to employer abuse. Accordingly, none of the Marshalls' causes of action is preempted by ERISA.

DISPOSITION

The judgment is reversed. The Marshalls to recover costs on appeal.

CERTIFIED FOR PUBLICATION

KLEIN, P.J.

We concur:

DANIELSON, J.

CROSKEY, J.

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[10] While overburdened California's courts may be willing to be relieved of employee insureds' tort actions, with over 100 million Americans covered by employer group health insurance, the federal courts are not eager to assume a vastly expanded jurisdiction over all disputes involving employee health insurance. (See *Massachusetts* v. *Morash, supra,* 490 U.S. at pp. 118-119).

APPENDIX C

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES

Case No: C 544 301

LINDA BROWN MARSHALL, DONALD MARSHALL,
Plaintiffs,

vs.

BANKERS LIFE AND CASUALTY COMPANY, an Illinois corporation; FRANK B. HALL AND COMPANY OF CALIFORNIA, a California corporation, MIA ADMINISTRATORS, a California corporation; and DOES 1 through 50, Inclusive,

Defendants.

JUDGMENT

[Filed Apr. 6, 1990]

1. This is a judgment upon the bifurcated trial of the thirteenth affirmative defense of the First Amended Answer of defendants, BANKERS LIFE AND CASUALTY COMPANY and FRANK B. HALL AND COMPANY OF CALIFORNIA to the Fourth Amended Complaint of plaintiffs, LINDA BROWN MARSHALL and DONALD MARSHALL.

2. Said affirmative defense states:

> "The First, Second, Third, Fourth, Fifth and Sixth Causes of Action of plaintiffs' Forth Amended Complaint are preempted by the Employee Retirement Income Security Act of 1974 (ERISA) 88 Stat. 829 as amended 29 U.S.C. Sections 1001 et seq."

3. Said bifurcated trial came on for trial on February 13, 1990, February 23, 1990 and March 2, 1990, in Department "44" of the Los Angeles Superior Court, located at 111 North Hill Street, Los Angeles, California, before Judge Norman Epstein, Greene, Broillet, Paul, Simon & Wheeler, by Timothy Wheeler and Randy McMurray appearing for plaintiffs, O'Neal & Wodin by Marc J. Wodin appearing for defendants.

4. Said trial was conducted upon a stipulation as to facts and evidence filed with the Court on February 28, 1990.

5. Said trial was taken under submission by the Court on March 2, 1990, following argument of counsel.

6. On March 8, 1990, the Court issued its decision on submitted matter, filed March 8, 1990, finding as follows:

> "The Court determines that the insurance program in this case is an 'employee welfare benefit plan' within the meaning of the Employee Retirement Income Security Act (ERISA; 29 U.S.C. Sections 1001 et seq.). Since it is, plaintiffs' causes of action are preempted by the federal statute. *Pilot Life Insurance Co. v. Dedeaux* (1987) 107 S.Ct. 1549; *Commercial Life Insurance Co. v. Superior Court* (1988) 47 C.3d 473.
>
> The employer's involvement in the program was not extensive. There is no evidence that it specifically intended to establish a program that would be covered by ERISA (cf. *Lambert v. Pacific Mutual Life Ins. Co.* (1989) 211 C.A.3d 456, 463). But the program that it did establish was for ongoing benefits of the kind typically covered by ERISA (cf. *Fort Halifax Parking Co. v. Coyne* (1989) 109 S.Ct. 1668 [lump sum payment of unused vacation time]).
>
> Here, the stipulated statement of facts establishes that the employer established the plan. It paid premiums for its employees, although the cost of

dependent coverage (involved in this case) was borne by the employee. (*Lambert* indicates that such payment brings the employer within the 'benefit coverage' aspect of the federal guidelines, 29 C.F.R. Sections 2510.3-1(j)(1); *Lambert*, 211 C.A.3d at p. 465).) The employer had the power to terminate the plan and collected dependent premiums from the employees and transmitted those funds, together with its own funds for employee insurance to pay coverage premiums. The employer also performed a number of administrative duties under the program such as disseminating insurance pamphlets to employees, handling enrollment forms and changes, answering questions about coverage and forwarding some questions to the plan administrator and assisting in claims processing. The employer did not handle money received by the administrator disburse benefits or make decisions about coverage or benefit payments on particular claims.

While the employer's involvement is not extensive, application of the ERISA standards to these facts, under established precedent (see *Rizzi v. Blue Cross of So. California* (1988) 206 C.A.3d 380 and cases cited; *Hughes v. Blue Cross of No. California* (1989) 215 C.A.3d 832, 853) leads to the conclusion that the involvement is sufficient to establish the benefit program as an ERISA plan.

Since plaintiffs' causes of action are therefore preempted, judgment must be for defendants. Counsel for defendants shall prepare the judgment and submit it to the Court.

The Clerk is directed to mail a copy of their memorandum to counsel of record."

7. Now therefore the Court orders that judgment be entered in favor of defendants, BANKERS LIFE AND CASUALTY COMPANY and FRANK B. HALL AND

COMPANY OF CALIFORNIA and against plaintiffs, LINDA BROWN MARSHALL and DONALD MARSHALL, with respect to the thirteenth affirmative defense of defendants' First Amended Answer to plaintiffs' Fourth Amended Complaint as aforesaid.

DATED: April 5, 1990

/s/ N L E
NORMAN L. EPSTEIN
Judge of the Superior Court

APPENDIX D

STATUTORY PROVISIONS

29 U.S.C. § 1002. Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

* * * *

(5) The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

* * * *

29 U.S.C. § 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under subsection (c)(2) or (i) or (*l*) of this section.

* * * *

29 U.S.C. § 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

* * * *

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, di-

rectly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

29 C.F.R. § 2510.3-2

(j) *Certain group or group-type insurance programs.* For purposes of title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which

(1) No contributions are made by an employer or employee organization;

(2) Participation the program is completely voluntary for employees or members;

(3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and

(4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.

APPENDIX E

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES

Case No: C 544 301

LINDA BROWN MARSHALL, DONALD MARSHALL,
Plaintiffs,

vs.

BANKERS LIFE AND CASUALTY COMPANY, an Illinois corporation; FRANK B. HALL AND COMPANY OF CALIFORNIA, a California corporation, MIA ADMINISTRATORS, a California corporation; and DOES 1 through 50, Inclusive,

Defendants.

STIPULATION

[Filed Mar. 1, 1990]

TO: THE INTERESTED PARTIES AND TO THEIR ATTORNEYS OF RECORD:

The parties to the instant matter, by and through their attorneys of record, hereby stipulate to the following facts as evidence in the bifurcated trial of the thirteenth affirmative defense of defendants' answer to plaintiffs' fourth amended complaint in the instant matter, to wit: "The first, second, third, fourth, fifth and sixth causes of action of plaintiffs' fourth amended complaint are pre-empted by the Employee Retirement Income Security Act of 1974 (ERISA) 88 Stat. 829, as amended 29 U.S.C., sections 1001, et seq."

DEFENDANTS' FACTS

1. Plaintiffs alleged that BANKERS LIFE AND CASUALTY COMPANY (hereinafter BANKERS), as insurer, and FRANK B. HALL & COMPANY OF CALIFORNIA/MIA ADMINISTRATORS (hereinafter HALL/MIA), as third party administrator, breached the common law duty of good faith and fair dealing and breached certain provisions of *California Insurance Code*, section 790.03, in failing and refusing to pay certain medical benefits allegedly due plaintiffs under a group health insurance policy issued by BANKERS to plaintiff DONALD MARSHALL's employer, MILLER IMPORT DATSUN, INC. (hereinafter MILLER), with respect to a certain hospitalization of plaintiff, LINDA MARSHALL, an insured under the subject policy, at Queen of Angels Hospital between May 5, 1983, and June 20, 1983.

2. BANKERS is an insurance company and was the insurance company which issued the subject insurance policy.

3. HALL/MIA is an administrator and acted in that capacity with respect to the subject insurance policy.

4. On or about February 18, 1983, MILLER applied to BANKERS for the subject insurance policy. On or about March 25, 1983, MILLER was advised by BANKERS that coverage was approved effective March 1, 1983.

5. The subject insurance policy, #3091, was in effect from March 1, 1983, to October 1, 1983.

6. MILLER provided this health insurance coverage to its employees as part of an employee benefit package.

7. The subject insurance policy was a policy which provided group, health, life and disability insurance coverage to employees of MILLER and their covered dependents.

8. All employees of MILLER were covered under the subject group insurance policy.

9. Plaintiff, DONALD MARSHALL, was an employee of MILLER and was enrolled as an insured under the subject insurance policy. Plaintiff, LINDA MARSHALL, the wife of plaintiff, DONALD MARSHALL, was enrolled for dependent coverage under the subject insurance policy.

10. MILLER purchased the subject insurance policy.

11. MILLER was billed for insurance premiums by HALL/MIA on a monthly basis and paid the premiums on a monthly basis.

12. MILLER paid the premiums out of its own account. MILLER had control over that account. It had the power to use (or misuse) the monies in that account. It had the power to use those monies to pay premiums or not.

13. The payment of these premiums were items which were recorded in MILLER'S financial records, including tax returns and monthly and annual financial reports.

14. MILLER paid the premium for employees, such as DONALD MARSHALL. MILLER paid these premiums in their entirety and did not deduct any sums for the payment of employee premiums from employees' paychecks.

15. MILLER paid the premiums for covered dependents, such as LINDA MARSHALL. It then deducted the amount of the premiums from the employees', e.g., DONALD MARSHALL's, paycheck.

16. MILLER added or deleted names of employees who were employed or terminated with dates of such employment or termination on monthly premium statements received from HALL/MIA and sent those changes to HALL/MIA to reflect new persons coming under the coverage and persons leaving the coverage for the purpose of adjusting premium payments under the subject insurance policy.

17. MILLER was provided with enrollment cards to enroll employees under the subject insurance policy. MILLER put the names of the employees on these cards, or some of them, and provided them to employees, who filled out the remaining portions and returned them to MILLER. MILLER sent the completed cards to HALL/MIA.

18. MILLER was provided with change forms which it provided to employees to fill out for the purpose of changing beneficiaries and adding or dropping dependent coverage under the subject insurance policy. MILLER sent the completed forms to HALL/MIA.

19. MILLER was provided with claim forms for employees to make claims under the subject insurance policy. MILLER provided these claim forms to employees to make claims under the subject insurance policy.

20. Sometimes, employees would have questions and/or problems with regard to enrollment, coverage changes and claims, or other matters relating to the insurance. In such case, persons at MILLER would attempt to answer such questions or resolve such problems. If they could not do so, they would contact persons at HALL/MIA or others, or place the employee in such contact.

21. MILLER was provided with booklets, "Your Group Insurance Plan," to provide to employees. Said booklet contained information with respect to the subject group insurance policy, including information as to "How to file claims for disability and medical expense benefits." MILLER provided these booklets to employees, including DONALD MARSHALL.

22. MILLER requested and obtained from HALL/MIA copies of a three page letter to employees with a brief explanation of the insurance coverage under this group insurance policy. MILLER provided this document to employees.

23. On one occasion, MILLER was asked by HALL/MIA to have an employee's beneficiary complete and sub-

mit a certain claimant's statement. MILLER gave the form to the employee. On another occasion, MILLER was asked by HALL/MIA to have an employee submit a waiver card for dependent coverage. MILLER gave the card to the employee to fill out. On another occasion, MILLER was asked by HALL/MIA to have an employee complete a health declaration to obtain dependent coverage. MILLER gave the form to the employee. On certain occasions, HALL/MIA sent information to employees with regard to their claims and sent this information through MILLER, who handed this information to its employees.

24. MILLER had the authority and right to cancel the subject group insurance policy and did so.

PLAINTIFFS' FACTS

1. BANKERS had a contract with HALL/MIA. The contract states, among other things, "Sec. 1. The agent hereby accepts appointment by the carrier to act as its agent in the administration of a plan underwritten by the above contract (policy), herein referred to as the plan. Sec. 2. The agent will perform duties in connection with the administration of the plan as directed by the carrier . . . ."

2. HALL/MIA provided a document to MILLER to be provided to its employees, which states, among other things, "All claims will be processed by MIA Administrators."

3. HALL/MIA provided a document to MILLER to be provided to its employees, which states, among other things, "If there are any questions regarding benefits or the processing of your claims, be feel free to call (Francie at MIA Administrators)."

4. MILLER was not required to provide any health insurance to its employees by any written contract or any collective bargaining agreement. The employee manual

did state that all employees would be provided with group health insurance coverage.

5. All claim forms were submitted to HALL/MIA. These claim forms were submitted directly by the employee or health care provider to HALL/MIA.

6. MILLER did not review any claim forms submitted to obtain benefits under the subject insurance policy.

7. MILLER had no responsibility for evaluating claims submitted under the subject insurance policy.

8. HALL/MIA or BANKERS had all of the responsibility for determining whether an employee or an employee's dependents were eligible for medical benefits under the subject insurance policy.

9. MILLER could not deny any benefits under the subject insurance policy.

10. MILLER never filed any reports with the Department of Labor with respect to the subject insurance policy.

11. Benefits under the subject insurance policy were paid directly to the employee or, at his direction, to the health care provider.

12. MILLER never handled any of the funds used to pay benefits under the subject insurance policy.

13. MILLER never had any opportunity to misappropriate or improvidently invest the funds used to pay benefits under the subject insurance policy.

14. MILLER did not intend to create an ERISA plan.

15. MILLER had no responsibility for monitoring how much money was available for paying claims under the subject insurance policy.

16. MILLER had no offices or employees outside of the State of California.

17. MILLER did nothing with enrollment cards or change forms filled out by employees other than sending

them to HALL/MIA, and, sometimes, putting a copy in the employees' files.

18. MILLER received no compensation or consideration from BANKERS for the subject insurance policy.

19. MILLER did not set aside a separate fund for the payment of insurance premiums.

20. DONALD MARSHALL was never told that this was to be an ERISA-plan.

21. DONALD MARSHALL was never informed that any rights or obligations he had under the subject insurance policy were rights or obligations under ERISA.

22. Employees of MILLER were also directed to contact HALL/MIA with any questions with regard to the subject insurance policy.

23. DONALD MARSHALL did call Francie Perez of HALL/MIA with questions about the subject insurance policy.

24. DONALD MARSHALL never spoke to anyone at MILLER with questions about the subject insurance policy.

25. HALL/MIA calculated and made all adjustments to the premiums to be paid by MILLER.

The parties to the instant matter, by and through their attorneys of record, further stipulate that the exhibits attached to this stipulation (defendants' exhibits 'A' through 'X' and plaintiffs' exhibit 1) are marked, as set forth in defendants' list of exhibits and plaintiffs' list of exhibits attached, and are admitted into evidence for and at the trial of the instant matter.

The parties to the instant matter, by and through their attorneys of record, further stipulate that the following depositions, the originals, of which, are attached hereto and lodged with the court, are admitted into evidence for and at the trial of the instant matter:

1. Robert LaVigne;
2. DONALD MARSHALL;
3. Francie Perez.

DATED: February 28, 1990

O'NEAL & WODIN

By /s/ Marc J. Wodin
MARC J. WODIN
Attorneys for Defendants
BANKERS LIFE AND CASUALTY
COMPANY and FRANK B. HALL AND
COMPANY OF CALIFORNIA

DATED: February 28, 1990

By /s/ Randy H. McMurray
RANDY MCMURRAY
Attorney for Plaintiffs,
DONALD MARSHALL and
LINDA MARSHALL